


3 1761 11971357 6



Digitized by the Internet Archive
in 2023 with funding from
University of Toronto

CA1
Z1
-69N21

167

COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

May 23, 1970
Council Chambers
City Hall
WINDSOR, Ontario

CA/
21
-69281

COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

BEFORE:

Gerald LeDain,	Chairman,
Ian Campbell,	Member,
H. E. Lehmann, M.D.,	Member,
James J. Moore,	Executive Secretary,
Marie Andree Bertrand,	Member,
J. Peter Stein,	Member,

RESEARCH:

Dr. Charles Farmilo,
Dr. Ralph Miller.

SECRETARY TO THE CHAIRMAN:

Vivian Luscombe.

May 23, 1970
Council Chambers
City Hall
WINDSOR, Ontario

Windsor, Ontario
May 23, 1970

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

--- Upon commencing at 9:45 A.M.

THE CHAIRMAN: Ladies and gentlemen, I call this hearing of the Commission of Inquiry into the Non-Medical Use of Drugs to order. I would just like to introduce the members of the Commission and our staff, who are here today. On my far right is Dean Ian Campbell of Montreal; on my immediate right, Dr. Heinz Lehmann of Montreal; I am Gerald LeDain; on my left, Mr. James Moore, Executive Secretary of the Commission; on Mr. Moore's left, Professor Marie Andrée Bertrand, Commissioner from Montreal; on Professor Bertrand's left, Mr. Peter Stein from Vancouver; and at the table to the left, Mrs. Vivian Luscombe, my secretary on the Commission, and Dr. Charles Farmilo, Research Associate on the Commission; Mr. Barry Hemmings, also on the Research staff, and also, Dr. Ralph Miller, Research Associate with the Commission.

I would like to begin by reading a statement which indicates some of the background of the appointment of the Commission, its terms of reference and the manner in which it has interpreted its task, at least in the initial phase of its inquiry.

The Commission of Inquiry into the Non-Medical Use of Drugs was appointed by the Federal Government on May 29th last year, upon the recommendation of the Hon. John Munro, Minister of National Health and Welfare.

The Commission has an indepen-

1 dent status under Part I of the Inquiries Act.

2 The concern which gave rise
3 to the appointment of the Commission is described in
4 Order in Council P.C. 1969-1112, which authorized
5 the appointment in the following words:

6 "There is growing concern
7 in Canada about the non-
8 medical use of certain drugs
9 and substances, particularly
10 those having sedative,
11 stimulant, tranquilizing or
12 hallucinogenic properties,
13 and the effect of such use
14 on the individual and the
15 social implications thereof;
16 --- within recent years,
17 there has developed also the
18 practice of inhaling of the
19 fumes of certain solvents
20 having an hallucinogenic
21 effect; and resulting in
22 serious physical damage and
23 a number of deaths, such
24 solvents being found in
25 certain household substances.
26 Despite warnings and con-
27 siderable publicity, this
28 practice has developed among
29 young people and can be said
30 to be related to the use of

1 drugs for other than medical
2 purposes;
3 --- certain of these drugs
4 and substances, including
5 lysergic acid diethylamide,
6 LSD, methamphetamines, commonly
7 referred to as "Speed", and
8 certain others, have been
9 made the subject of controlling
10 or prohibiting legislation
11 under the Food and Drugs Act,
12 and cannabis, marijuana, has
13 been a substance, the
14 possession of or trafficking
15 in which has been prohibited
16 under the Narcotic Control
17 Act;
18 --- notwithstanding these
19 measures and the competent
20 enforcement thereof by the
21 R.C.M.P. Police and other
22 enforcement bodies, the
23 incidents of possession and
24 use of these substances for
25 non-medical purposes, has
26 increased and the need for an
27 investigation as to the cause
28 of such increasing use has
29 become imperative."
30 In announcing the Commission's

1 appointment, the Minister of National Health and Welfare
2 spoke of the "grave concern felt by the government at the
3 expanding proportions of the use of drugs and related
4 substances for non-medical purposes".

5 The terms of reference
6 defining the Commission's inquiry into the non-medical
7 use of psychotropic drugs and substances mention
8 sedatives, stimulants, tranquilizers and hallucinogens.

9 For the present, the Commission
10 understands "drug" to mean any substance which
11 chemically alters structure or function in the living
12 organism, and "psychotropic" drugs as those which
13 alter sensation, feeling, consciousness and psycholo-
14 gical or behavioural functions. The Commission has
15 tentatively defined "medical use" in terms of generally
16 accepted medical practice -- under medical supervision
17 or not. All other use is "non-medical use".

18 By itself, a prescription
19 does not distinguish medical from non-medical use. A
20 non-prescription drug like aspirin may be taken for
21 medical use. Or a prescription drug may be taken for
22 generally accepted medical reasons, then no longer
23 required.

24 The Commission is invited by
25 its terms of reference to "marshal...the present fund
26 of knowledge concerning the non-medical use of
27 sedative, stimulant, tranquilizing, hallucinogenic and
28 other psychotropic drugs or substances".

29 But since an interim report is
30 expected shortly, and a final report within two years,

1 the Commission will have to be selective.

2 It must consider what appear to
3 be the principal issues which led to its appointment.

4 The Commission has the
5 initial impression that its primary focus must be on the
6 non-medical use of drugs by the young and by adults
7 as it relates to or affects the use of drugs by youth.

8 The Commission has drawn up a
9 preliminary classification of psychoactive drugs; which
10 falls into the following eight categories: hypnotics-
11 sedatives; stimulants, psychedelic-hallucinogenics;
12 opiates-narcotics; volatile solvents and gases;
13 analgesics (non-narcotic painkillers); clinical anti-
14 depressants; and major tranquilizers.

15 The Commission sees its
16 primary emphasis on the following categories:

17 1. The psychedelic-hallucinogenic, which includes
18 cannabis (marijuana and hashish), LSD and mescaline and
19 the other "restricted drugs" placed under the new
20 schedule J of the Food and Drugs Act: DMT, STP (DOM), and
21 DET;

22 2. The stimulants, including such amphetamines as
23 benzadrine and methadrine --- generally referred to as
24 "speed";

25 3. The volatile solvents and gases -- often referred to
26 as "delirients", such as glue, nailpolish remover, and
27 paint thinner;

28 4. The sedative-hypnotics, such as the barbiturates
29 (used as sleeping pills), the minor tranquilizers, and
30 ethyl alcohol;

1 || 5. The opiate-narcotics; such as heroin.

Alcohol and nicotine are clearly mood-modifying drugs used for non-medical reasons and therefore within the terms of reference. However, the Commission could not possibly perform its task if it were required to consider the extensive research carried out on these substances. A realistic view compels the Commission to regard the non-medical use of alcohol and nicotine in their relations to the non-medical use of other psychotropic drugs. This is also the Commission's position, at least initially, on the non-medical use of the opiate-narcotics, such as heroin.

These so-called "hard drugs" are not excluded from the terms of reference; because they do have psychotropic properties. But as with alcohol and nicotine, the Commission cannot hope to do justice to the extensive literature on the subject. The "hard drugs" are therefore to be examined in their possible relationship to the non-medical use of the "soft drugs".

Two contentions brought to the Commission's attention may illustrate what is meant by "relationship" to the non-medical use of soft drugs.

The first contention is that extensive social use of alcohol not only creates a permissive climate of drug use, but also reflects a provocative injustice and even hypocrisy in our legislative and law enforcement attitudes. The second

1 contention is that the use of certain soft drugs like
2 cannabis (marijuana) leads very often, if not generally,
3 to hard drug addiction.

4 What are the issues in this
5 inquiry? The Commission must investigate the extent
6 of the non-medical use of mood-modifying drugs in
7 Canada. That means the pattern of drug use; the
8 drugs and various groups or populations involved,
9 according to age, occupation, etc.; the movement from
10 one drug to another.

11 The Commission must
12 investigate physical and psychological effects of
13 these drugs; effects on behaviour of the individual
14 concerned, effects on others, and effects on society.
15 Finally, and by no means least important, the
16 Commission must investigate the reasons for the non-
17 medical use of drugs -- not only the personal reasons
18 or motivation, but the social, educational, economic
19 philosophic and other reasons. In other words, what is
20 the meaning or larger significance of this phenomenon?
21 What is the true nature of the challenge it presents
22 to our civilization?

23 We have accepted a very
24 difficult task and we need your help. It is imperative
25 that we have the views of as many Canadians as possible.
26 This is not solely a technical question for experts;
27 it is a broad social issue, going to the very nature
28 of human existence in our time. It is a question to
29 which everyone can contribute a measure of insight and
30 wisdom. Please come forward and assist us with your

1 | views.

2 | I should just like to say a
3 | few words about the manner in which we proceed. There
4 | will be an opportunity at the end of each of the
5 | scheduled submissions for questions and comments by
6 | the Commission and by others who are present. We have
7 | placed microphones in the aisles for your convenience
8 | and it is not necessary to have a formal, much less a
9 | written submission here today. We are anxious to have
10 | the benefit of your views and it has been our experience
11 | across the country that we have had a good public forum
12 | in these hearings, and a good exchange of views so
13 | that we hope that you will assist us today.

14 | (portion in French)

15 | I will call now on Mr. W. A.
16 | Wilkinson, President of Prescription Services, Inc.

17 | Mr. Wilkinson, if you will be
18 | seated at the table.

19 | Mr. Wilkinson?

20 | MR. WILKINSON: My name is
21 | William A. Wilkinson and I am President of Prescription
22 | Services Incorporated. We are the operators of the
23 | Green Shield Prescription Plan which is a totally
24 | prepaid prescription plan which provides prescribed
25 | medicine in the same manner as a Medicare programme
26 | supplies medication or supplies the medical services
27 | of the doctor.

28 | My background is in pharmacy,
29 | I am a graduate of 1931; I have spent the first thirty
30 | years of my professional life as a pharmacist. I

1 invented and developed the Green Shield Plan and
2 produced it to a full scale operation in 1965 and since
3 then I have spent my entire time as an Administrator
4 of an organization which has prescription services of
5 over 3/4 of a million every year, and collections in
6 excess of \$3,000,000.00 every year which is a fair
7 sized operation.

8 With your permission, sir,
9 I would like to read a brief that is not that long,
10 and I think it details the single object of which I
11 am appearing.

12 The purpose of this brief
13 is to focus the attention of the Committee on the
14 problems of utilization of pharmaceuticals as applied
15 or related to the operation of a prepaid drug plan.

16 A prepaid drug plan has a
17 similar operation to that of the prepaid medical plan
18 with the exception that instead of medical services
19 provided, the patient's premium payment entitles him
20 to receive a broad range of prescription drugs which
21 are prescribed by medical or dental practitioners and
22 dispensed by registered member pharmacists.

23 The Green Shield Prescription
24 Plan is operated by Prescription Services Inc. which is
25 an Ontario corporation without share capital having its
26 headquarters in Windsor, Ontario, and a sales office
27 in Toronto. The Green Shield Plan offers its prepaid
28 prescription plan on a Canada wide basis to industry
29 and labour through group enrollment. At the present
30 time the Green Shield Plan insures nearly 155,000

persons who during 1969 received from member pharmacists over 750,000 prescriptions. The Plan commenced in 1958 but during the next five years operated only as a pilot plan in order to establish programs and procedures and to identify, if possible, norms with respect to prices and utilization so that proper premium charges could be established. By 1965 a sufficient body of information as well as an enrollment of a sufficient number of subscribers upon which to make meaningful assumptions was achieved and subsequently through computerization a bank of administrative information and statistical material has been built up. This provides the Green Shield plan with a recall capability enabling the plan to provide various agencies and commissions of government with a wide variety of accurate data in addition to providing all the necessary information required for internal administration. As an example, Prescriptions Services Inc. has already tendered to the commission a study of utilization patterns in 18 therapeutic classifications of pharmaceuticals including the 6 classes of the most "abuse likely" drugs. A further copy of this study is appended to this brief.

In the operation of the Green Shield Prescription Plan, the following factors are of significance:

- the cost of ingredients per prescription
- the pharmacists fee
- the number of prescriptions per person per year
- The average utilization to the patient of a prescription
- the utilization of prescription drugs which is calcu-

1 lated on a month to month basis and is expressed in
2 the number of prescriptions per thousand per person
3 insured per month.

4 While all of these factors are
5 of significance in the operation of the Plan, for its
6 purposes the Commission will be more interested in the
7 utilization of prescription drugs. Nevertheless
8 comparisons in the increases in utilization with the
9 increases in the costs of services and professional
10 fees are of some interest. In 1965 utilization of
11 drugs in the Green Shield Plan was 284 prescriptions
12 per thousand insured persons per month, while in 1969
13 the utilization had risen to 408 prescriptions per
14 thousand insured persons per month, and this represents
15 a rise of 124 prescriptions or 43%. In 1965, the
16 average price of a prescription drug was \$3.47 while in
17 1969 that average price (according to the Canadian
18 Pharmaceutical Association survey) had risen to \$3.78,
19 an increase of approximately 9%. Green Shield figures
20 for the cost of ingredients (on which payments to
21 pharmacists are based) in 1965 were \$1.82 but by 1969
22 this figure had risen to \$2.05 which is an increase
23 of approximately 12-1/2%. Thus considering inflation
24 and the rising costs of goods and services in the
25 economy generally, an increase in the price of prescrip-
26 tions of about 9% and an increase in the cost of the
27 ingredients of about 12-1/2% is probably somewhat less
28 than the average of increased costs of other goods and
29 other services for that four year period. Thus it is
30 evident that the most significant figure in all of our

1 prescription data is utilization. In terms of utilization
2 the increase in the same four year period was about 44%
3 or roughly 4 times the increase in the other factors.

4 This leads to consideration of
5 the nature of utilization of prescription drugs.

6 Referring to the appendix to this brief, the Commission
7 will observe that of a total of 99 therapeutic classifi-
8 cations, only 6 are the most abuse likely but those
9 6 represent roughly 50% of the number of prescriptions
10 dispensed, the total dosages and the total dollar
11 value of drugs dispensed, as well, and the actual
12 figures are as follows. Here, in a small table, we have
13 placed the mood modifiers. The percent of the number
14 of prescriptions dispensed is 26. Twenty-six percent
15 of all the prescriptions dispensed were mood modifiers
16 including tranquilizers, sedatives, amphetamines.
17 Forty-one percent of the total dosages fell in that
18 same category and 32% of the total number of dollars
19 fell into that same category.

20 Now as to pain relievers and
21 analgesics, anti tussives and anti histamines, most of
22 these fall in this classification, 21% of all the
23 prescriptions fell in that classification, 16% of all
24 the dosages and 14% of all the dollars.

25 So in these 6 categories we have
26 46% of all the prescriptions that were dispensed, we
27 have 57% of all the doses and 46% of all the dollars.
28 And the other 93 classifications, therapeutic classifi-
29 cations, made up the balance of the 100%.

30 DR. LEHMANN: Excuse me, what

1 do you mean by all the dosages?

2 MR. WILKINSON: In our data
3 we are able to keep a running total on the number of
4 pills, tablets, capsules, teaspoonfuls or in whatever
5 form that prescription was dispensed. If your
6 prescription was for 60 tablets, 60 tablets is charged
7 against your account and we are able to make a running
8 total by patient, by drug, by doctor.

9 THE CHAIRMAN: It is by units,
10 in effect.

11 DR. LEHMANN: Units.

12 MR. WILKINSON: Yes, a capsule,
13 a tablet ---

14 MR. CAMPBELL: Would that data
15 differentiate in terms of dose, if the standard dose was
16 3 tablets? Would this show here as 3 doses or as 1
17 dose?

18 MR. WILKINSON: No, no, it is
19 a physical tablet or a physical capsule. If the
20 directions were to take 2 tablets, 3 times a day, that
21 is 6.

22 MR. CAMPBELL: I see.

23 MR. WILKINSON: The dosage is
24 very significant, if I may say, in other analysis because
25 the ordinary dose of a certain capsule for instance is
26 about 1 in the evening or 1 before bedtime and the
27 normal dose of a tranquilizer during the day may be
28 4 tablets a day. In each case the physician therapeuti-
29 cally is trying to come to an objective. It may take
30 4 tranquilizers or 1 sleeping pill to keep you asleep

1 for four hours.

2 May I proceed?

3 THE CHAIRMAN: Yes.

4 MR. WILKINSON: Prior to the
5 advent of prepaid prescription plans the view was
6 widely held among physicians and pharmacists alike that
7 many persons, both parents and children went without
8 prescribed medicine simply because they could not
9 afford either the physician home or office call, or the
10 pharmacists prescription. However, utilization figures
11 for the Canadian population prior to the Canadian
12 Sickness Survey of 1951 were practically non-existent
13 and as it later turned out owing to the methods adopted
14 in that survey the drug utilization figures proved to
15 be unreliable and for a prepaid plan quite misleading.
16 In addition, few of the pharmaceuticals now in use
17 were developed and many of the brand name pharmaceuticals
18 now in considerable use were not on the market.
19 Furthermore the development of oral hypoglycemic agents
20 from the sulpha family introduced the age of tranquilizers.
21 Amphetamines were also introduced within this period.
22 These drugs are unquestionably abuse prone or abuse
23 likely. In a broad sense the tendency to abuse is
24 related to the condition of our society, which has
25 come to rely upon drugs of all shapes, sizes and kinds
26 as an answer for all ills, actual or imagined. For
27 many problems, both physical and mental, perhaps being
28 disabilities being brought on by the stresses of our
29 modern and complex society, it is evident that a great
30 reliance has been placed by the public upon the six

1 abuse prone categories of drugs. It is necessary of
2 course to draw the distinction between the medical
3 utilization of drugs and the abuses which are really
4 the non-medical use of drugs. Naturally we do not
5 have any competence to comment on the first point
6 which is solely a matter lying within the field of
7 medicine and for concern of the physicians, but we do
8 suggest that some steps could be taken in relation to
9 the non-medical use of drugs.

10 We have suggested the 6 cate-
11 gories of drugs may be said to be susceptible to abuse.
12 You may well ask whether this is so, whether abuse
13 exists and if so in what manner. A prepaid prescription
14 plan of course removes from public concern the question
15 of the costs of the drug dispensed. The subscriber is
16 concerned only with the amount of his premium payments
17 and not with the actual cost of the ingredients or the
18 professional fee to the pharmacist for dispensing them.
19 Thus the normal action of the market place, at least
20 in terms of public scrutiny of cost, is suspended. The
21 abuse thus occurs assisted largely by the existing
22 legislation which authorizes repeat prescriptions. As
23 the Commision is no doubt aware, a repeat prescription
24 is one issued by a physician which authorizes the
25 dispensing of a particular drug by a pharmacist for a
26 stated number of times at stated intervals (provided
27 however, that it is not one of the narcotic or controlled
28 drugs). The significant point, however, is neither the
29 pharmacist nor the patient requires a further authority
30 from the physician or his review of the necessity for

1 the prescription after the original prescription is
2 filled.

3 Some of the abuses with respect
4 to repeat prescriptions are as follows:

5 (a) an insured person will receive a repeat prescription
6 and will then either give, sell or share that prescrip-
7 tion or part of it with a neighbour, a friend or a
8 relative while securing a refill for the insured person's
9 own needs and thus continue in this custom at least up
10 to the limit of the authorized supply.

11 (b) secondly, a teenager will obtain a drug from a
12 parent for the teenager's own use or for trafficking.

13 This may represent the contents or part of the contents
14 of a prescription, particularly those of the barbiturate
15 or amphetamine categories which have a significant value
16 in dollars when used in trafficking. In most of these
17 instances the parent is either unaware or unconcerned
18 with the loss of the dispensed drugs, but in any event
19 the parent is quite capable of obtaining a repeat of the
20 drug for the parent's own use without any further
21 requirement of reattendance upon the physician.

22 (c) Sometimes there will be a patient collusion with an
23 unscrupulous pharmacist. For example the patient will
24 exchange his prescription, (or at least that portion
25 that he does not require), with the pharmacist for credits
26 for general merchandise. In these instances the
27 unscrupulous pharmacist will charge the prepaid plan for
28 drugs not actually dispensed, while at the same time the
29 collusive patient draws other goods and services from
30 the pharmacists by way of credit. It is also worth

1 noting that as the pharmacist has charged the plan with
2 the drugs dispensed, those drugs have left his
3 inventory and are available for further trafficking.

4 (d) Sometimes repeat prescriptions are issued in which
5 either the number of authorized repeats or the stated
6 intervals of the time of use are not described. In
7 these events the patient or the pharmacist is obviously
8 in a position to fill up the number of repeats and the
9 time intervals which again of course creates abuse.

10 There are of course other
11 methods by which abuse occurs which are not related to
12 repeat prescriptions, for example a patient may exert
13 pressure on his doctor to issue the prescription in
14 the name of an insured person. We also suggest that
15 these examples do not exhaust all the methods by which
16 abuse occurs as a result of repeat prescriptions.
17 Nevertheless we submit that the principal reason for
18 abuse is the repeat prescription.

19 As the Commission will appreciate
20 it is difficult to identify exactly the extent of
21 utilization abuse or its impact in dollars upon a
22 prepaid plan. The point, however, is that with the
23 introduction of the prepaid plan comes abuse. What
24 is more significant is the impact of drug utilization
25 abuse on a universal government operated drug plan
26 available to the whole population. In this case, I
27 might interject, we are trying to look ahead to the day
28 when there probably will be a universal drug plan and
29 what the abuse factors are likely to be, if there is not
30 remedial legislation. Thus if by one or more of the

1 abuse devices we have indicated the abuse factor amounted
2 to five per cent of the total cost of drugs in any year
3 there would be
4 a staggering cost to the plan. In the Green Shield
5 submission to the Medical Services Inquiry of Ontario
6 we estimated the total cost of the drugs dispensed in
7 the first year of a universal government plan for the
8 whole of Canada to be about 360 million dollars, rising
9 rather rapidly to the fifth year to about 700 million
10 dollars. On this basis and an assumption of a five
11 per cent abuse factor the additional cost to the plan
12 would range from 18 to 35 million dollars annually and
13 probably at least would be equal to the administrative
14 cost of the program.

15 The present legislation, both
16 provincial and federal, relating to drugs does not touch
17 on drug prescribing. The present legislation relates
18 solely to records that must be maintained when drugs
19 are dispensed and in addition restricts the dispensing
20 of drugs amongst a relatively narrow segment of the
21 population who have qualifications for that purpose such
22 as, for example, physicians and pharmacists. Unless,
23 therefore, some steps are taken to regulate - in fact
24 eliminate - the use of repeat prescriptions, it will
25 not be possible to eliminate the abuses which we have
26 described. It is important, naturally, not to interfere
27 with the doctor-patient relationship but at the same
28 time steps obviously must be taken against the
29 artificial utilization which is brought about by a
30 straight abuse. In our opinion if legislation were

1 effected (which could be done both provincially and
2 federally) prohibiting repeat prescriptions in their
3 entirety, most, if not all of these abuses would
4 disappear. In every instance then when a patient
5 requires a prescription the physician would determine
6 the dosage and the time within which the dosage is to
7 be used. At the same time the physician would review the
8 patient's requirements anew each time the prescription
9 is to be filled. It might be argued that this would
10 increase the costs of medicare by increasing the medical
11 charges for each review but a reference to British
12 practice, where repeat prescriptions have been prohibited
13 since about 1948, would indicate the contrary. It may
14 very well be that the potential of the patient's need
15 to be scrutinized by the physician upon the repeat
16 prescription being required has been sufficient to deter
17 the abuse prone patient, who in fact had no need of the
18 repeat. We also observe that the British practice permits
19 some flexibility to the physician, in that in appropriate
20 circumstances additional prescriptions may be issued so
21 long as each one is a separate prescription and so long
22 as the intervals of time within which the prescription
23 may be used are clearly specified. Additionally, house
24 calls are dealt with by permitting the prescription to
25 be issued by the physician with the pharmacist being
26 authorized to dispense the prescription upon a telephone
27 order provided that he picks up the written prescription
28 within 24 hours thereafter.

29 As we have already stated it
30 is not within our competence to comment usefully upon

1 the medical utilization of drugs except perhaps to
2 suggest that public disclosure of the extent of drug
3 usage by society will be useful in bringing society to
4 an understanding of a need for a balance or control of
5 its drug requirements. For the non-medical use of
6 drugs, however, we recommend to the Commission that the
7 legislation be effected both at the provincial and
8 federal level for the prohibition of repeat prescriptions
9 on the basis which we have outlined herein.

10 Thank you.

11 Attached is a 1968 survey,
12 Table 1 gives the eighteen categories, therapeutic
13 categories of prescription drugs which we have compiled
14 from our Data Bank. You will note the tranquilizers,
15 Number one. These are listed again as number of pres-
16 criptions, doses and ingredients. At the request of
17 the Coordinator of the Drug Plan, the Ontario Drug Plan,
18 on Table 2, we projected what we believed would be the
19 provincial utilization of these same drugs based on our
20 experience. It is a value judgment. The multiplication
21 factor arrived at is our own, but if you look at Table 2
22 you will see that in 1968 we estimated that there was
23 something like 97,436,000 doses of tranquilizers over
24 a cost of \$11,000,000.00 and that ranging down. And
25 on Table 3 which is two pages, we have tried to put
26 together the mood modifiers as tranquilizers, hypnotic-
27 sedatives, amphetamines and anti depressants, and we
28 have worked out the number of prescriptions, the doses
29 and the dollars and also the order in which they appear
30 on the list. Underneath them are the pain relievers,

1 the cough, cold allergy type anti histamines which are
2 abused, and those are the two which I mentioned at the
3 beginning of our presentation. On Table 3 continued,
4 there is another classification of abuse prone
5 pharmaceuticals in what we call anti spasmotic sedatives.
6 We did not include them in the first part of the brief
7 but in any overall consideration of this, they should
8 be taken into consideration because they do amount to
9 3% of prescriptions, and 6% of the doses, and 4% of
10 the dollars, and they could easily be added to the 6
11 categories which I gave you in the beginning because
12 these are the mild sedatives, which contain some small
13 amounts of a medication for cramps in the tummy and
14 anti spasmotics, but taken in large doses by the
15 handful they are in the same category as the other
16 abused drugs. I have tried to total at the bottom
17 The 17 categories are 88% and the 82 categories are
18 only 12%. And so the 1968 estimated pill consumption
19 from prescriptions in Ontario is something in the
20 order of 19,224,600 prescriptions for 547,845,300 doses
21 and \$70,753,300.00. I would estimate that while they
22 are our own figures, I would think the possibility
23 there would be perhaps a 5% error. There is one other
24 factor about repeats which we did not put in our
25 brief because we thought we would like to bring it out
26 in questioning and that is the patient, what we know as
27 the patient initiated repeat which occurs from the
28 patient having had a prescription, immediately upon
29 using the last of it, returns to the pharmacist and
30 says, "repeat my prescription." And he consults the files

1 --- and I have some files from March here, and he
2 consults the file and sees that this, in the first
3 instance, was a telephoned prescription or a prescription
4 without any repeat authorization on it, so he says,
5 "that's fine, Mrs. Brown, come back after you go to the
6 grocery store and I will contact the doctor and I will
7 get permission for you." So the pharmacist, as a
8 consequence of this and the number of times it happens,
9 either employs a separate person who has a telephone
10 growing out of his or her ear and they are on the
11 'phone continuously obtaining these repeat authorizations
12 on behalf of the patient. The sad, very sad part of
13 this is the doctor almost never gets the message. He
14 doesn't get the inquiry and he doesn't authorize the
15 repeat and in most cases, no knowledge that the
16 authorization was given by some member of his staff.
17 I have no idea how we can measure this except perhaps
18 have members of the Commission stand in a pharmacy
19 for a day or a half a day and see what really goes on.
20 I have got with me some samples of original prescriptions
21 which the physicians indicated repeats on. We have a
22 number here, I have tagged them, where the physician
23 will indicate 24 repeats, 12 repeats, 6 repeats and
24 sometimes these run as high as several hundreds of
25 dollars --- a blank cheque for several hundred dollars
26 worth of either that prescription or other medication.
27 I have one here that was photocopied. I would like to
28 read it into the records. It is a prescription for
29 Indicin. Now Indicin is one of the newer drugs. It is
30 a drug for gout and that type of problem, and in the

1 appendiment there is a monogram of about a page and
2 a half or two pages indicating the class indications
3 and dangers of this drug. I have here, written pres-
4 cription for 100 - 2 capsules after the noon and
5 evening meal, repeat 30 times. That is 3,000 prescrip-
6 tions --- 3,000 doses. This^{is}/enough for quite some
7 time aside from the dollar value. The
8 physician was contacted on this, and I have his quote.
9 He was contacted by another physician and asked if he
10 didn't think this was rather the wrong thing to do as
11 not a good practice of medicine, and he states, "first
12 there is some doubt in my mind whether the thirty
13 repeats on this had been raised from twenty." It
14 looked as if^{it}/had been written over, so we asked ---
15 we inquired as to whether that was actually his hand-
16 writing. He stated that repeat thirty times may be
17 his handwriting, he is not sure. He states that
18 however, rather than be incessantly bugged by the
19 pharmacists for repeat prescription authoritation, he
20 will put in any number of repeats that comes to his
21 mind at the time and since he has been on medication ---
22 this patient has been on this medication for many,
23 many years, he has no qualms about removal of the
24 problem from the druggist. This is not an isolated
25 case. It is the rule rather than the exception. I
26 had a prescription which is not in my files, but for
27 a birth control pill, repeat 100 times. This is
28 enough for a period of^{ten}/years of a medication which is
29 considered not to be all that safe.

30 I would be glad to answer any

1 questions, sir.

2 THE CHAIRMAN: Dr. Lehmann?

3 DR. LEHMANN: I should like
4 some interpretation. In your appendix you distinguish
5 between amphetamines and anti depressants. Now what
6 anti depressants do you have in mind? Because on
7 another Table you equate amphetamines with anti
8 depressants which obviously is not a very psychological
9 and psychiatric practice and you do that and later you
10 take it apart. Now what do you mean by that on Table
11 1 on the range of utilization?

12 MR. WILKINSON: The anti
13 depressants --- if I may just for a second refer ---
14 the anti depressants are a category of drugs, as you
15 know there is Aventyl, there is Desoxyn, Desoxyn
16 Gradumets, Elavil, Etrafon, Eutonyl, Nardil, Pertofane,
17 Ritalin, Tofranil --- these are all mood raisers
18 without being the amphetamine type which is a non-
19 appetite depressant, but at the same time a mood
20 raiser. These are the mood raisers that are not
21 amphetamines.

22 DR. LEHMANN: Well, Desoxyn
23 isn't amphetamine is it?

24 MR. WILKINSON: Yes, I think
25 you have to put Desoxyn in there to. It would be in
26 both.

27 DR. LEHMANN: So it is in
28 both.

29 MR. WILKINSON: Yes.

30 DR. LEHMANN: Well in all

1 psychiatric literature and in our practice for some
2 years now it has been pointed out again and again as
3 accepted practice that amphetamines are not to be
4 used in the treatment of depression, and therefore are
5 not to be included under anti depressants. There
6 used to be --- and it has been a practice and it has
7 been realized for many years now that Tofranil, Aventyl
8 and Desoxyn are specific anti depressants, not
9 the amphetamines or methamphetamines. But you
10 distinguished between amphetamines and other anti
11 depressants and Aventyl and Tofranil and so on. Now
12 do you have evidence that they are much abused and
13 where is the evidence, because you have them as the
14 most abused factors?

15 MR. WILKINSON: I think what
16 we are saying here, is that we are not a policing
17 organization. We assume that there is abuse when we
18 discover a very high frequency of utilization and
19 when we ---

20 DR. LEHMANN: Well that is
21 quite an assumption. Insulin then would be terribly
22 abused because it is used for a lifetime and has very
23 high instance of utilization. Now you don't have it
24 on your abuse column categories.

25 THE CHAIRMAN: Well as I
26 understand it, this schedule simply shows an estimate
27 of abuse and whether we characterize abuse or not is
28 another question. But these are what you consider
29 reasonable estimates of the use of anti depressants?

30 MR. WILKINSON: Yes sir.

1 THE CHAIRMAN: And that is
2 an established fact.

3 DR. LEHMANN: But I mean it
4 isn't an important issue. Because that would mean it
5 is prone for non-medical use. It is not abuse
6 prone according to this categorization.

7 THE CHAIRMAN: What do you
8 think those things ---

9 DR. LEHMANN: The hypnotics,
10 anti histamines, some of the tranquilizers are indeed
11 very prone to non-medical use, so that is what we are
12 interested in.

13 THE CHAIRMAN: I see.

14 DR. LEHMANN: Others are
15 included which are not, so therefore it is confusing.

16 THE CHAIRMAN: I see.

17 DR. LEHMANN:--the condemnation
18 with non-medical use prone drugs.

19 THE CHAIRMAN: Is there no
20 medical use of anti depressants?

21 DR. LEHMANN: Very little. I
22 would like to know about this. In fact the same is
23 true for tranquilizers. Of course, I suppose you have
24 here also the phenothiazines and (unintelligible)
25 and if anything, these drugs are just the opposite.
26 They are usually not taken by the physician --- by
27 the patient. You do not include the

28 MR. WILKINSON: We would be
29 glad to go into that with you, Doctor, if you would
30 care to, in our establishment and show you the various

1 categories. If I can get back to your original question,
2 the reason we use amphetamines as a separate therapeutic
3 concentration is that in our initial stages of operation
4 of the Plan, these came on the market as diet pills
5 for use in diets.

6 DR. LEHMANN: I understand
7 the amphetamines all right.

8 MR. WILKINSON: We gave them
9 a separate code number so they can be pulled out
10 separately. Now, all we are saying to you in this
11 submission is that we can detail the utilization of
12 these various categories and we can give you the
13 number of doses ^{and} dollars and prescriptions with
14 one category in relation to another category and we
15 would not propose to get into the therapeutic use of
16 these, except that we are showing the number --- the
17 extent of the use of them. Now we know, and I am sure
18 that everyone who has watched this scene knows that
19 drugs which produce a euphoric effect

20 or desirable effect/^{as} what we term abuse prone.
21 And that is if I am using it and I find it gives me a
22 lovely feeling I am likely to tell my neighbours on
23 either side of me and I am likely to lend them the
24 medicine and get myself some. So abuse prone is in that
25 sense.

26 DR. LEHMANN: Well, may I
27 point out then that quite a number, and this is precisely
28 the point I want to make, a number of the drugs you
29 have included in these abuse prone categories do not
30 give a lovely feeling and produce euphoria and in fact

1 produce the opposite and therefore are very often not
2 taken by the patient when they should. For instance,
3 phenothiazine, very often (inaudible), and they do not
4 elevate the mood. The mood elevator is not the same as
5 an anti depressant. An anti depressant is a drug which
6 lifts a pathological depression or removes it. A mood
7 elevator is a drug which produced euphoria regardless of
8 whether if there is depression present or not. The
9 amphetamines are in this category, but not Tofranil and
10 a tranquilizer, a drug that gives a euphoric feeling
11 like a barbiturate or Doriden something like this, or
12 Valium might fall into this category, but not the so-
13 called nature tranquilizer which is usually included
14 and I am afraid it is in yours. The phenothiazene they
15 are the drugs that should be prescribed for years and
16 years, but are not abuse prone. So I am afraid there
17 is a little mix up with the categories, and therefore
18 these phenomenal sounding doses are really not--
19 sometimes not so formidable.

20 There was one other question, and that
21 was about the repeat prescriptions. Obviously the
22 example you gave sounds pretty awful or is pretty
23 awful. On the other hand, what is the patient going
24 to do, go to the doctor each time when he needs a
25 repeat prescription? That would pose quite a financial
26 hardship and other hardships on him, and many of these
27 prescriptions, for instance the barbiturate prescriptions,
28 should not be ideally given in more than 15 doses at a
29 time. Now, it might be repeated, then if the date
30

1 would be stated, as it should be stated, that it should
2 be repeated once or twice or three times, what would be
3 the objection to this, a hundred times is a different
4 story, but suppose it would be --- there would be a
5 limit to the repetitions, two or three times with the
6 date stated. Would you agree that might be a possible
7 compromise? Or what would you say about the need for
8 the patient to go back to the doctor every time, taking
9 his time very often--it is impossible for him to see
10 enough patients in a day, taking his time just for the
11 repetition and paying for it.

12 MR. WILKINSON: Well ---

13 THE CHAIRMAN: I was
14 wondering, we might have a number of further questions,
15 this is important, a valuable submission to us, and I
16 am wondering, Mr. Wilkinson, if you would be good
17 enough to consent to having a Doctor introduced at
18 this time. He has got to be at the hospital in ten
19 minutes and we have scheduled a submission from this
20 doctor, Dr. Wachna, and if we could hear him, otherwise
21 we won't be able to hear him, and then we can resume
22 our questions of you. Would you mind doing that?

23 MR. WILKINSON: Oh no, I
24 would be glad to comply.

25 THE CHAIRMAN: Thank you very
26 much. Doctor, would you like to take your place at
27 the table here?

28 DR. WACHNA: Mr. LeDain,
29 Members of the Commission. Thank you, Mr. Wilkinson,
30 and I think I will discuss the problems because I have

1 some answers for you. The doctors in this city are
2 not necessarily out to give repeat prescriptions, but
3 I think you have to communicate with them more. I
4 think maybe if you set your limit to one month and be
5 firm about it, you will be quite pleased with the
6 results.

7 I am a practicing physician
8 in Windsor and for the past five years have pursued a
9 type of medical research into the use and abuse of
10 hallucinogenic drugs. Two weeks ago, I attended an
11 annual meeting of the Ontario Medical Association in
12 Ottawa where a symposium on hallucinogenic drugs was
13 held with four doctors, both from Canada and the
14 United States, and a lawyer from Toronto participating.
15 The conclusion reached as summed up by the legal
16 panelist was that "the medical profession, whether it
17 is ready for it or not, is the principal group to
18 inform the government or the public as to the seriousness
19 of the non-medical use of drugs in our country."

20 My purpose in presenting this
21 brief is to further stress the need for immediate
22 action concerning the present-day picture of drug abuse
23 and its deleterious effects. This is based on five
24 years of research with patients, I might say patients
25 that I delivered twenty years ago; I know their
26 personalities right from the day they were born and
27 I see them now, also in clinics and in addiction centres,
28 besides attending many symposiums on drug dependency.

29 Many briefs have been presented
30 to you in the past and have been devoted primarily to

1 the legal status of marijuana. As a practising physician,
2 I am totally opposed to legalization because I believe
3 that we have reached epidemic proportions of drug abuse,
4 not only in the "soft" drugs, but also the "hard" ones
5 such as heroin, as stressed at the Ontario Medical
6 Association two weeks ago in Ottawa. Inasmuch as drug
7 dependency has become a significant problem in all of
8 the industrialized countries of the world, I believe
9 that in the case of addiction, you can safely say that
10 where there is smoke there is fire.

11 It is regrettable that it has
12 been so long --- that it has taken so long to collect
13 repetitious data from all parts of Canada which is the
14 purpose of the Commission, but I hope that you will
15 present a report to the Federal Minister of Health and
16 the Government of Canada, very soon, that will stress
17 positively the dangers of these drugs, and assist the
18 government to take strong action in protecting the
19 citizens of the country against this dreadful dependency.

20 The goal should not be to
21 eliminate drugs entirely, which is impossible, but to
22 control them and to diminish their allure, by offering
23 other valid alternatives, a life of challenge and
24 fulfillment, which in Canada we can certainly all
25 expect.

26 I am certain that you have
27 heard many versions of the effects of hallucinogenic
28 drugs, but in my estimation, (I repeat) my estimation,
29 the one presented by the Ontario Addiction Research
30 Foundation in Toronto was most scientific and timely.

1 Inasmuch as I have affiliation with the Addiction Centre
2 in Lexington, Kentucky, I might as well tell you I
3 visited the place, twice in five years. They admitted
4 the same thing, that in Canada, the Ontario Addiction
5 Research Foundation is presenting very, very good
6 reports, and they are working in conjunction with
7 Lexington.

8 A sociologist in Hamilton
9 who spoke to you a week or so ago presented only
10 one aspect of the problem. I remember that you
11 congratulated the said person, but not stressing the
12 damage done to the brain in the long run, or the
13 addiction that follows to heroin, which has been
14 proven many, many times in all of the cities in North
15 America and through the world over. And therefore,
16 I want to present a more scientific report.

17 Perhaps the best brief was
18 submitted by an admitted drug addict in Regina where
19 it says "drugs give youth more courage to break windows
20 and fight police. In order to fight you old people we
21 need strength. Maybe after the revolution we won't need
22 dope. We see an enemy and must join our brothers
23 around the world in the fight. The enemy is not just
24 the police but the people who made North American
25 society capitalistic. The thing you people should do
26 is smoke pot with us." This is a true picture of
27 chronic LSD and pot users. That is what I have learned
28 in five years. I must stress one thing, namely, that
29 all drugs act according to the dosage used. For instance,
30 marijuana can produce a mild euphoria, very true, and

1 maybe very little harm to it. But if smoked heavily,
2 the effect on the perception centres in the brain is
3 entirely different, because in each case it is a chemical
4 reaction, and this is one thing I want to stress, that
5 the actions that go on in the brain with all these
6 hallucinogenic drugs are chemical actions. They are
7 not something that dissolves a cell or some medium, it
8 is a reaction, it is a chemical action. Perhaps you are
9 not aware of the fact because in Ottawa at the symposium,
10 they were not. I was rather surprised. They were not
11 aware of the scientific fact where absolute proof shows
12 that at present at the University of Michigan, Ann Arbour,
13 the Pharmacology Department has isolated thirty-two
14 derivatives from marijuana--now we thought there were
15 only two or three--each one being more toxic than the
16 other, and they are called tetrahydrocannabinols. It
17 is extremely important not to under-estimate the
18 potential danger of marijuana, not only in its tendency
19 to lead to heroin addiction and to cause distortion of
20 perception and personality changes, but also that it
21 effects the young age group and you know about the
22 public schools in every city, I hope--have produces
23 drop-outs which is a very sad thing. It has produced
24 drop-outs at all levels of education. Somehow or
25 other the young age groups want to be part of the
26 drug culture.

27 Present day violences on
28 college and university campuses are definitely related
29 to drug users, and recently at the Kent State University
30

1 they found guns, knives, brass knuckles, and halluci-
2 nogenic drugs. Because marijuana is not too easy to
3 obtain in the United States at present, many of the
4 users are switching to amphetamines or "speed", and it
5 was discussed earlier, which is known to kill. I know
6 amphetamines very well. Mainlining is a very dangerous
7 thing. With the increase of these various drugs, there
8 has been a decided increase in the rate of crime,
9 accidents, rape and suicide, not to mention that the
10 marijuana traffic amounts to \$850,000,000.00 a year.
11 Someone is making a lot of money.

12 Recently a psychiatrist in
13 Detroit, addressing the Family Services Group had this
14 to say; "The individual using the drug wants it to do
15 the living for him or her." I repeat this is a very
16 good ending that he had, "The individual using the drug
17 wants it to do the living for him or her." The most
18 important report published in my estimation by the
19 National Institute of Health stated that marijuana is a
20 dangerous drug and should be treated as such, recommending
21 that users be given a weeks' education programme on
22 uses and abuses of these drugs and its dependency,
23 instead of just sending them to jail. And I agree there
24 is no use sending them to jail. It appears that the
25 educational programme of drugs should be directed to
26 all segments of the population, starting with kindergarten,
27 according to the Ontario Medical Association symposium.
28 Now we have to start in kindergarten. The users of
29 these drugs --- last page, claim that they attain great
30 philosophic truths and keen artistic expression. These

virtues, ladies and gentlemen, do not exist in plants and chemicals but are found in men themselves. Therefore, because further use of marijuana will only add to the problems of society, and not solve any, I repeat, and not solve any, we are anxiously awaiting your report, and hope that the government will act immediately to inform the people of Canada and the world who are looking and watching what Canada is going to do --- and the world, how really dangerous these drugs are. To surrender to the pushers and importers would be disastrous.

Perhaps a couple of lines from a letter written by a son, who committed suicide, in February --- not in Windsor --- I am not going to mention where --- I have the letter --- to his father, and it would be well to add to this brief. He wrote, "Dope ruined my life, and took away my happiness forever. Please don't hate me too much for what I have done. I hope people taking these drugs will find out sooner than I did. Good bye father, and love me. Your son, Ricky."

Thus, the medical profession, the teaching profession, the legal profession, the clergy and all civil agencies in every village, every town and every city in our country have a responsibility and have to be mobilized in a well-directed dramatic crash programme of education and discipline --- I repeat of education and discipline. I made a fair study of various consultants in different cities about this concerning the greatest threat to our civilization

namely the use and abuse of these dangerous hallucinogenic drugs.

Finally, allow me to paraphrase
a passage from Hamlet:

To legalize or not to legalize pot,
That appears to be the question,
Whether 'tis nobler for the mind to think clearly
alone, or with the use of hallucinogens become
psychedelic or perchance even psychotic.

Such is the drug dependency scene today that makes calamity of our life, be it young or old, and loses the name of action and the glory of our country.

But alas, the LeDain Commission is here and a general awakening is sure to follow.

Thank you.

THE CHAIRMAN: Thank you,
Doctor.

MR. STEIN: You mentioned in your statement, it was your belief that chemicals were not able to be the cause of creativity, and of greatness in people --- I think you made that point --- did you not? In other words that the claims to creativity on the part of people who had used chemicals seemed to be a bit absurd, and it was people who were the ones who made themselves great. Is that what you were saying?

DR. WACHNA: No, I was referring to a specific chemical reaction that hallucinogenic drugs do to the very centre of the brain. It was not as if it was a dissolving thing, it is a reaction.

1 It is a chemical reaction. But certain chemicals--
2 alcohol perhaps to a point, can cause creativity--
3 I am not going to say that, but I am saying that these
4 drugs have been proven, and I might tell you that in
5 post mortem cases where they find suicide cases, they
6 are looking for changes in the brain, and I want to
7 tell you I have seen them too, at Lafayette Clinic in
8 Detroit where there are little dark, dark bodies in
9 the brain and these according to a psychiatrist with
10 all due respect to Dr. Lehmann, are irreverisble damage
11 due to LSD alone, so far--LSD alone, so far, they
12 found.

13 MR. CAMPBELL: You spoke Doctor,
14 of a five year period, as aperson involved in research.
15 Could you tell us something about the research program
16 and the type of sample you have used, the pyhothesis
17 produced in the research and so on?

18 DR. WACHNA: First of all it started
19 with a symposium and lasted, I guess, until the
20 American Association introduced the total awareness
21 to me that something was happening in the world with
22 these hallucinogenic drugs that we, as medical students
23 knew nothing about. Immediately, I took a special
24 course and became familiar with every drug that has--
25 with its uses and abuses and so forth. And then of
26 course, I was involved in a survey in our schools--
27 I have children going to school. I was somewhat
28 concerned about things that were happening, and also
29 patients that were coming to my office that I had
30

1 delivered, and this is the way I have been collecting
2 my data and also following the research programmes at
3 Lexington and Toronto in the Addiction Centre. I had
4 many users and now, I say, a lot of them are not using it
5 now. I have had sessions with them and many, many
6 discussions and also revelations in recent weeks only.
7 A lot of them are quitting now, I might say.

8 MR. CAMPBELL: Now you spoke
9 of brain damage as a consequence of drugs. Was this a
10 general statement, that you applied?

11 DR. WACHNA: No, it is not a
12 general statement, I just mentioned that I was at
13 Lafayette Clinic and I saw ^{it} when a psychologist and
14 pathologist showed it to me, and I believe that at the
15 University of California and at Berkley where they have
16 more cases than anybody else, they have found very
17 definite brain damage.

18 MR. CAMPBELL: I am not
19 disputing the question of brain damage. I am simply
20 trying to pin down the specific drugs. You were
21 referring to LSD?

22 DR. WACHNA: LSD, yes, not pot,
23 no. LSD is definitely on the list.

24 MR. CAMPBELL: And then your
25 reference to violence. Could you be more specific there
26 about the particular drugs you spoke of, an increase in
27 crimes of violence, crimes such as rape; were you
28 speaking here generally of psychoactive drugs?

29 DR. WACHNA: I have had
30 considerable experience. On the list I would put

1 amphetamines first. The psychiatrists don't always,
2 but I think amphetamines work very rapidly and there
3 is no time for deliberation, it is a sudden rash
4 decision and they do it. And I think marijuana is
5 becoming an offender now, too, because remember that
6 those thirty-two derivatives, we are just learning
7 about them now, but already they have isolated thirty-two
8 derivatives.

9 MR. CAMPBELL: When you are
10 speaking of the tetrahydrocannabinols you said that
11 each is more toxic than the other. Could you expand
12 on that slightly?

13 DR. WACHNA: The pharmacologists
14 that addressed us, and I have all the data on that,
15 referred to the fact that the experimentation that they
16 are conducting right now on animals, seems to indicate
17 that each one is becoming more toxic.

18 MR. CAMPBELL: This is each
19 in sequence of which they are isolated?

20 DR. WACHNA: That is right.

21 MR. CAMPBELL: Could you give
22 us the name of the pharmacologist?

23 DR. WACHNA: Yes I can. He
24 is Head of the Pharmacology Department, University of
25 Michigan, Ann Arbour. I communicated with him also last
26 summer and at the Lafayette Clinic. I think it is a
27 scientific fact, even if they don't discuss it in
28 Ottawa --- I mention it because I think it is vital.
29 We know that opium has derivatives and now we find out
30 that marijuana has thirty-two derivatives. And I just

1 found that out last fall.

2 MR. CAMPBELL: You spoke of
3 a need for strong action by the State. What do you
4 mean by "strong"?

5 DR. WACHNA: I don't think
6 we should pussy foot any longer with whether there is
7 harm or no harm. I think we are dealing with
8 dangerous drugs. If I am wrong, you will have to prove
9 it to me.

10 MR. CAMPBELL: I am not
11 disputing this for a moment; I simply want to know what
12 you mean by "strong action".

13 DR. WACHNA: Strong action.
14 Instead of having some little excerpt in some little
15 reference, I think we have to go all out on the
16 biggest educational programme that we have in our
17 country and bring the facts on every media because you
18 know some of the media doesn't agree with my remarks.

19 MR. CAMPBELL: Now when you
20 say education, what would be the purpose of this
21 education?

22 DR. WACHNA: Facts. People
23 don't have the facts Mr. Campbell. The facts. They
24 must have the facts.

25 THE CHAIRMAN: I assume there
26 are some positive favourable things that could be said
27 about particular drugs. Would you agree that these
28 facts should be given as well?

29 DR. WACHNA: Oh, certainly.
30 Now I might tell you that as far as amphetamines are

1 concerned, I am not going to stop using amphetamines
2 because if I give a patient a capsule a day to lose
3 weight, I am getting results. It is the abuse that's
4 bad. I have been using amphetamines for years. But
5 I never give them more than thirty and that's for a
6 whole month.

7 MR. STEIN: Would you see any
8 possibility that moderate use of marijuana is similarly
9 capable, in effect, of not producing bad results? In
10 other words, you seem concerned about heavy use. Do
11 you suggest that there is, in your estimation from the
12 facts as you know them, or assess them, do you suggest
13 that any use of marijuana is necessarily abuse or is
14 your concern the heavy chronic use?

15 DR. WACHNA: Well I am not one
16 to disagree with you totally. I hope some day we will
17 find some good uses for marijuana. There may be some --
18 euphoria; there may be some. I haven't found any yet,
19 but maybe we will find some one of these days. I know
20 that the bad chronic cases are serious, are serious.

21 MR. STEIN: Do you also feel
22 a deep concern about the present use --- excessive
23 use of alcohol. Do you think we should launch the same
24 kind of educational programme?

25 DR. WACHNA: Well we have one
26 major problem now, I don't think you want another.

27 MR. STEIN: I am saying in
28 light of the difficulties we have with alcohol, do you
29 feel we ought to also similarly approach our young
30 people in kindergarten or whatever, with programmes ---

1 DR. WACHNA: But we are
2 approaching them about alcohol. Alcohol is not as
3 severe. It does not cause as severe a reaction as
4 hallucinogenic drugs and you know that you could
5 recover quite readily from alcohol. But all I have
6 learned about, so much about these hallucinogenic drugs.
7 You never know what this drug is going to do to you,
8 remember that. You never know. You might be all right
9 the next day or you might not be all right the next
10 day. With alcohol you have a hangover, but with
11 hallucinogenic drugs you don't know how you are going
12 to be tomorrow.

13 MR. STEIN: You mentioned
14 earlier that your feeling of law, as I understood your
15 comments, that jail was not the solution. What is your
16 view about the appropriate use of law in relation to
17 this phenomena, in other words, what is your impression
18 about the way the law ought to look?

19 DR. WACHNA: I really don't
20 thing --- I think it is useless to put users in jail
21 and not give them an education. I will tell you
22 frankly ---

23 MR. STEIN: Of all drugs or
24 just hallucinogenics?

25 DR. WACHNA: I am talking
26 about hallucinogenic drugs, mostly. I think that the
27 more education we have about, number one, hallucinogenic
28 drugs, the better, and the lawyer in Toronto made it
29 very clear to us also that we shouldn't really think
30 that because we are going to put someone in jail, we

1 are going to improve the situation. We don't improve
2 it at all.

3 MR. STEIN: What about heroin
4 users?

5 DR. WACHNA: I think heroin
6 users are very, very bad right now.

7 MR. STEIN: Do you think
8 heroin users should be put in jail?

9 DR. WACHNA: Institutions,
10 because we can do more specific treatment for them.

11 MR. STEIN: What sort of
12 a treatment in an in an institution are you thinking of?

13 DR. WACHNA: You know about meth-
14 done treatment. I am not saying it is very effective,
15 but you have been reading about heroin abuses in England
16 where they have centres, where everybody came and got
17 their own heroin. All cut off. Why? No end to it. It
18 got progressively worse. So I think that heroin is an
19 advanced case of drug abuse, and it requires really
20 hospitalization, but not some of these --- I think the
21 walk in and out patient service is rather good for the
22 ordinary type, but heroin is an entirely different
23 story.

24 DR. LEHMANN: Dr. Wachna, may
25 I come back a minute to alcohol. You said all that is
26 wrong with it is you may get a hangover and wake up and
27 yet you know the next morning it will be over in a few
28 hours. Well, in your practice, haven't you seen quite a
29 number of physical ravages of alcohol, delirium tremens,
30 deaths, liver cirrhosis, break up^{of}/families due to

1 physical brain damage. So you don't mean to say that
2 there is no physical damage due to alcohol?

3 DR. WACHNA: No, that is another story.
4 I am not disagreeing with you at all, Dr. Lehmann, I
5 am just saying that is a small percentage, of course.
6 How many cirrhosis do I see a year out of maybe
7 several hundred people who are really alcoholic?
8 But I agree that alcohol in time, if it is going to be
9 chronic alcoholism, can be as bad as some of these drugs,
10 yes. I am not going to disagree on that. But we are
11 discussing one important issue of the day.

12 THE CHAIRMAN: I think, Doctor,
13 we have kept you a long time and we should release
14 you now.

15 DR. WACHNA: Thank you.

16 THE CHAIRMAN: Thank you very much.

17 DR. WACHNA: Thanks kindly and
18 thank you, Mr. Wilkinson.

19 MR. WILKINSON: It is a pleasure.

20 THE CHAIRMAN: Mr. Wilkinson?

21 DR. WACHNA: Did you want a brief?

22 MR. STEIN: The question Dr. Lehmann
23 posed to you, and I hope it is not too long a
24 period for you to recall the question, because I
25 was quite interested in what your view might be;
26 Dr. Lehmann, you were asking whether or not a
27 compromise on repeat drugs, something like
28 three, might be of value and how realistic it
29 was to expect people to return each time.
30

1 MR. WILKINSON: Well, I think,
2 and I am trying to find a repeat prescription card here,
3 there can be any number of alternatives to tighten up on
4 the repeat prescription regulations. I suggest that
5 we should study very closely the method that the British
6 have used under the National Health Service in England
7 since its inception. It may be that
8 they have gone too far in order to put the ceiling on
9 the expense of drugs. Certainly the system we have
10 today is no control at all. It makes liars of us all.

11 I have with me the hang up
12 card and this is produced by the Ontario College of
13 Pharmacy and I suppose you have seen this. It is
14 supplied to all pharmacists and physicians concerning
15 repeat prescriptions, covers both the provincial laws
16 and the federal laws and tells the prescriptions that
17 may be filled or may not be refilled, which schedule
18 they fall in, whether they are narcotic controlled drugs
19 or prescription required drugs, and exactly the procedure
20 that the pharmacist must follow. As you can see, it is
21 quite complicated and I^{am} sure you don't want to go over
22 each item. The fact of the matter is this is no control
23 at all except paper control. It controls nothing. And
24 as long as the pharmacist is going to be permitted to
25 solicit repeats under pressure from a patient and, in
26 addition, and let's be fair, it maximizes his income.
27 Just so long as this is permitted, and just so long as
28 physicians are as busy as they are, some member of the
29 staff of that doctor's office will authorize that
30 prescription. Now the person who authorizes it, may

1 have had a two week course at a typewriting
2 school and she authorizes the pharmacist who
3 has had five years training, a number of years work
4 and experience to authorize a prescription for a
5 very dangerous drug.

6 DR. LEHMANN: But what about
7 the system which might be proposed where the
8 pharmacist or pharmacist's secretary or some
9 person there would phone in and inquire at the
10 doctor's office for the doctor to call him,
11 the pharmacist, back? Either the doctor or
12 his agent must give the word. If you can't
13 get him immediately, it will be up to him
14 to phone back every pharmacist. That would
15 still be better than having to see the patient
16 again, and the patient having to make another
17 visit and so on.

18 MR. WILKINSON: But, Doctor,
19 it doesn't work. This is what has been the
20 law from---as long as I have been in the
21 drug business---?
22 --- (portion inaudible)
23 (They prefer). . .
24 If the doctor doesn't have to leave his patient.
25 In other words, the receptionist phones so and so
26 pharmacy and give a prescription authorization and
27 asks "Is it all right?" And the doctor shouts back, "Yes".

28 DR. LEHMANN: Obviously it confuses
29 the whole thing, but is it still more difficult for
30 the doctor to see the patient. So if the regulation

1 could be enforced that the Doctor personally would have
2 to make a telephone prescription to the pharmacist, what
3 would be wrong with that?

4 MR. WILKINSON: This is the
5 regulation we have, Doctor, and it doesn't work.

6 DR. LEHMANN: It should be
7 enforced. It would be less workable to impose a greater
8 hardship on the patient and the doctor, it seems to me.

9 MR. WILKINSON: Nothing is free,
10 doctor. If you are going to have better control, you are
11 going to have to pay for it, and you may have to pay for
12 it in your time, in your effort, or you pay it in money.
13 The pharmacist may pay for it, but you are not going to
14 get this control free. He should be willing to give up
15 some of his time to exercise market control and we are
16 not going to have it if we are going to allow this slip-
17 shod control to go on, we will never proceed on abuse
18 of drugs, never. And the choser that we get to third-
19 party payment, the greater the problem will be--it is a
20 license to steal is really what it is.

21 DR. LEHMANN: It could be.

22 MR. WILKINSON: It is. It
23 just couldn't be; it is unethical practice and I ask
24 you, Doctor, to go and spend a day or two in a pharmacy.
25 You will come to the same conclusions I have. You will
26 be appalled and it won't take you more than a day.

27 To answer your specific
28 question, if I were writing the legislation, I would
29 prohibit all repeats, and I would go directly to the
30

1 British system and it has worked for over twenty-two years
2 it has worked and I think we can learn a great deal from
3 it. If we feel that it needs some relaxation, it will
4 not be too difficult to devise a method. For instance,
5 you say that it would be inconvenient for a person
6 on continuous medications such as an
7 epileptic. There is no reason why this patient can't
8 be given three prescriptions or four prescriptions at
9 stated intervals, each slip of paper. They go and have
10 those prescriptions filled when the due date of those
11 prescriptions comes up.

12 THE CHAIRMAN: What is the
13 difference between that and a repeat prescription?

14 MR. WILKINSON: Because it
15 is dated, it has a date on which that prescription may
16 be filled again, and when those two or three prescriptions
17 are gone, there are no more, and the person can't get a
18 fourth, fifth or sixth by simply making a telephone
19 call.

20 DR. LEHMANN: The dates could
21 be stated on the repetition.

22 THE CHAIRMAN: On a repeat
23 prescription.

24 DR. LEHMANN: On one prescription.

25 MR. WILKINSON: This would be
26 great if that would happen. Here are a thousand
27 prescriptions in these two books. There is a space on
28 every prescription for the doctor to write in the
29 repeat number of times and interval between the repeats,
30 and they are never filled in. There might be three in

1 500 filled in.

2 THE CHAIRMAN: It is a question
3 of enforcement.

4 MR. WILKINSON: There doesn't
5 seem to be a way, by actual experience, Doctor, and I
6 think one of the reasons you have a Commission
7 investigating this is to find out why the system doesn't
8 work. One of the reasons this system does not work is
9 that none of this is enforcible.

10 DR. LEHMANN: There seems to
11 be collusion between the doctors and the pharmacists.
12 If both would simply make it stick, there is no way
13 how it couldn't work.

14 MR. WILKINSON: Doctor, it
15 is not collusion, it is the line of the least resistance.
16 A physician is under tremendous pressure for his time.
17 The pharmacist is under tremendous pressure by the
18 patient, "Get me my prescription or I'll deal somewhere
19 else. A combination of these events just make the
20 system unworkable and the reason I am here is to try
21 and point out that it is an unworkable system and to
22 make a suggestion as to how it can be changed.

23 THE CHAIRMAN: Well, the
24 suggestion, as I take it, necessarily involves more
25 expense by the patient and more expenditure of
26 time for the physician so that it is a question of
27 self discipline; it is a question of sacrifice of some
28 kind. It is not a question of an improved regulation.
29 I mean, the point is that are the professions going to
30 make the effort? I mean you describe a new

1 regulation. You are well on the way to convincing
2 us that the present one is not working because there
3 is no will behind it to make it work. So what is to
4 be the professional initiative on it? What I mean, you
5 know, we can echo your evidence, give it emphasis, but
6 what is the outlook for professional response here?

7 MR. WILKINSON: We suggest,
8 Doctor, and ---

9 THE CHAIRMAN: I'm not afraid
10 of guilt by association, but I'm not a doctor, I am a
11 lawyer.

12 MR. WILKINSON: We suggest
13 that there have to be regulations placed on the
14 availability of the repeat prescription, and the
15 easiest way to do it would be to build a British system
16 and see how they work and see if we can't copy it.
17 Surely if a country of 50,000,000 people can introduce
18 this where they ^{have} complete medicare and where they pay
19 the doctors for all of these calls, then surely we,
20 with a small population, can do something similar. And
21 if we cannot, then I am sure that we can improve
22 something that hasn't completely and totally broken
23 down because of the telephone. As long as repeat
24 prescriptions over the telephone are permitted, then
25 we will have this situation prevailing and one step in
26 the right direction, if you want to take it by steps.
27 and one of the alternatives that I would suggest, is that
28 the telephone repeat would be completely
29 outlawed. In other words, the pharmacist has to produce
30 the physician's signed prescription with a stated number

1 of repeats on it, and no telephone prescriptions would
2 be accepted on a repeat basis, and the pharmacist would
3 be responsible, as in the British system, to acquire
4 the signed prescription within twenty-four hours after
5 the doctor phoning in, whereas the doctor initiates the
6 telephoned prescription. The pharmacist fills it, then
7 he has twenty-four hours to get it from the doctor's
8 office or through the mail. All telephone prescriptions
9 would be outlawed.

10 THE CHAIRMAN: Well, I want
11 to understand better just precisely what the possible
12 abuse here is. Is it the fact that the repeat is being
13 merely authorized over phone by one of the doctor's
14 staff without speaking to the doctor, or is it possibly
15 the fact that it may be authorized by the doctor without
16 seeing the patient? What, precisely, do you think is
17 happening in terms of the authorization of repeats?
18 Are doctors, themselves, in your judgment authorizing
19 repeat prescriptions without an adequate basis for
20 assessing the need, because they aren't seeing their
21 patient? I want to know what the problem is in terms
22 of telephone repeats.

23 MR. WILKINSON: At the risk
24 of taking a little bit too much time, the Doctor
25 assesses the patient's condition and writes the
26 prescription.

27 THE CHAIRMAN: Initially.

28 MR. WILKINSON: Initially.

29 MR. CHAIRMAN: Right.
30

1 MR. WILKINSON: And unless
2 it is what we call, a hot narcotic, the pharmacist may,
3 at the patient's insistence, 'phone the physician's
4 office at any time and ask if the office will okay a
5 repeat. Now this is a blank cheque for any patient
6 to get any amount of repeats. Quite often you can
7 'phone the wrong doctor and get an okay for a repeat ---
8 very simple. And I will do it for this afternoon if
9 you like.

10 THE CHAIRMAN: Well you are
11 talking about the prescribing practices of the
12 physicians. Is this the problem we are talking about
13 this morning, not about the telephone, not about ---
14 the prescribing practices of the physician.

15 MR. WILKINSON: It is all a
16 part of the same problem that hinges on these regulations
17 which amount to a paper control over a very serious
18 problem. And because of the size of the physician's prac-
19 tice, because of the pressure of the patients, because
20 of the desirability of medication, and because it is
21 great to be a great fellow and share your medication
22 with your sister-in-law or next door neighbour so that
23 they will have the same tranquilizing effect, the
24 result is that these desirable drugs have become very,
25 very easy to get and an original prescription, unless
26 ^{for} it is/a narcotic, becomes easily accessible to anyone
27 to get and to give to their neighbours. Now here is
28 where we find --- at least we believe, is the abuse of
29 the prescribed drug. Now as long as there is a third
30 party payment in the hands of free enterprise, we can

1 always adjust our premiums to take care of this abuse,
2 and we have. Our premiums today are some 30% higher
3 than they were five years ago and the reason is to
4 take care of this abuse. But when you add drugs to
5 Medicare, as you no doubt will, how does one take care
6 of the abuse? How does one take care of the blank
7 cheque that we have given to 20,000,000 people to have
8 almost unlimited access at almost any time to medication
9 because we have paper controls?

10 THE CHAIRMAN: But you don't
11 have proof, actually, of abuse. A repeat prescription
12 is not, per se, an abuse. A repeat prescription is a
13 valid medical prescribed practice where it is indicated
14 for valid medical reasons. So with the exception of
15 one or two examples which you gave us, which was raised
16 certainly, as a ^{presumption} of abuse and faulty prescribing
17 practice, you don't have actual proof that the repeats
18 in the cases which you have encountered, were wrong
19 prescriptions; do you?

20 MR. WILKINSON: I don't
21 understand what you mean "wrong prescriptions".

22 THE CHAIRMAN: Not necessary,
23 or prescriptions that were not justified for medical
24 reasons.

25 MR. WILKINSON: Well we have
26 proof of this Mr. LeDain, and that is we have any
27 number of cases where we have engaged the services of
28 a detective agency to go and discover why these drugs
29 have been passed from one person to another. I have
30 here with me ---

1 DR. LEHMANN: I beg your
2 pardon. That jumped a certain logical point there .
3 It is still possible that the repetition of the
4 prescription was justified medically, but that it then
5 was not used by the patient, but the patient gave it
6 to somebody else in spite of the fact that the doctor
7 might have been justified in prescribing it for him.
8 Now you won't get around that somehow, because even if
9 the patient would get another prescription, and then
10 pass it on to his mother-in-law, well ---

11 MR. WILKINSON: Please don't
12 misunderstand me; I am not generalizing that all doctors
13 do these things. I am saying that this type of control
14 is the vehicle, if you can call it that ---

15 THE CHAIRMAN: It lends itself
16 to abuse, that is what you are saying, and you are saying
17 that the levels of consumption are suggestive of abuse.
18 They look to more than exceed reasonable medical require-
19 ments in your judgment as a pharmacist?

20 MR. WILKINSON: In our views
21 they do. And certainly the figures of a 44% rise in
22 5 years would indicate there is something quite wrong.

23 DR. LEHMANN: And you want to
24 counter it by making it harder to obtain prescription
25 drugs. That is really what it would mean because there
26 are, as you say, other options, such as having the patient
27 take the responsibility for making the doctor call the
28 pharmacist, and so on. But it would be much more difficult
29 for the patient to go, perhaps spend an hour on the bus,
30 an hour coming back home, when a woman has children at

1 home to take care of and so on, having to go to the
2 doctor's office to get a new prescription, that could ---
3 would you admit, could, in certain cases, result in the
4 patient not getting a prescription when the patient
5 should get a prescription?

6 MR. WILKINSON: I wouldn't
7 characterize it that way at all, Doctor. I would say
8 in response that this regulation on repeats is more
9 difficult than if we had no regulation at all. And
10 what we are talking about is a matter of degree. If we
11 were to tear this up entirely and simply say, "narcotic
12 drugs may not be repeated," period, paragraph, which is
13 what this says, and leave all the rest of it off, that
14 would be the easiest possible thing. And maybe that is
15 what we should do, or maybe we should make it just a
16 little harder. What we have got is very easy, if we
17 tear it up --- it is harder now, it is quite inconvenient.
18 Why the telephone call? It is a sham. Let's do away
19 with it and go right to the easy or let's put a few
20 more regulations in here and make this effective.

21 So what I'm speaking about
22 anyway, is the matter of degree. I think that the
23 physician should be required to take a little more time
24 about the repeats. I think that the pharmacist should
25 be prohibited from bothering the physician to death with
26 telephone calls. I think that the physician should be
27 able to order the medicine that he needs at the time he
28 needs it for the patient, and that the patient shouldn't
29 be able to initiate all of these repeats himself and
30 have open access to medication. And I believe you won't

1 get that unless you are willing to pay the price of
2 having a little greater responsibility on a physician
3 and a greater responsibility on a pharmacist until
4 these controls are effected.

5 THE CHAIRMAN: Do you have
6 the figures for the amphetamine consumption before
7 1968? Is there any basis here for/how the consumption
8 has developed in recent years?

9 MR. WILKINSON: No we don't,
10 Mr. LeDair. We used 1968 because we were doing a
11 project for the Ontario Government. We will be doing
12 the same project at the end of 1969 in July or August,
13 and we will make a comparison of 1969 and 1968.

14 THE CHAIRMAN: Would you send
15 us your findings?

16 MR. WILKINSON: Yes, we would
17 be happy to. I can tell you that the preliminary ---
18 quantity surveys which I have done without going into
19 the computers at all, simply based on numbers of
20 prescriptions and numbers of dollars/^{I think}are going to be
21 about 70% higher in prescriptions and in dollars, per
22 thousand people than we were in 1968. It looks as though
23 this is the case.

24 THE CHAIRMAN: So it is moving
25 at about a 6% to 8% increase per year?

26 MR. WILKINSON: I think it
27 ^{somewhere}will be between 5% and 7% per year.

28 PROF. BERTRAND: Supposing we
29 should take your alternative and tear off that page and
30 write that narcotics should not be repeated. What would

1 be the social cost --- what would be the moral cost
2 involved, do you think, in getting narcotics?
3 Supposing that this regulation would lend itself to
4 the usage that the person or apparently the Canadian
5 people want to make?

6 MR. WILKINSON: If I
7 understand your question, what you are saying is if
8 you take all the bars and let them all down I did
9 not suggest that.

10 PROF. BERTRAND: You mentioned
11 that as an alternative we could also say, which I
12 think would be closer to what is actually happening,
13 only narcotic drugs should be repeated, or that the
14 actual repeat procedure lends itself to such an abuse,
15 that it amounts to nothing.

16 MR. WILKINSON: This would
17 only be a very subjective suggestion, and I don't
18 think it would make a bit of difference. I think we
19 effectively have no control now. We are going through
20 the charade of telephoning somebody at the other end
21 of the telephone. It may be the doctor's wife, or whoever,
22 and going through this kind of charade of getting
23 permission to repeat all of these prescriptions, except
24 the narcotics, which, of course, must have a signed
25 prescription. And when I suggest that we have no
26 repeats, I am only saying that we should apply the
27 rules to all drugs which presently prevail to the
28 narcotic drug today. It is just as difficult today to
29 get a narcotic as it ever was. It doesn't work
30 entirely, because we have narcotics on the street, but

1 it works at least for prescription medication, and I do
2 not believe that having to have a new prescription each
3 time for a narcotic has caused that much hardship for
4 either the patient or the doctor that we could not use
5 this same regulation and apply it to all of these drugs.

6 PROF. BERTRAND: If I could
7 just pursue this a bit. Maybe I'm not--I'm asking
8 you to step out of your field, but I would like to know
9 why you feel that the actual abuse situation should be
10 controlled--should be somewhat changed. What is
11 your assumption that, under the fact, that the Canadian
12 population is using too many drugs? Why do you feel
13 that it should be changed?

14 MR. WILKINSON: Well, I
15 suppose that is another social judgment. It gets a
16 little upsetting when you pick up a patient's record
17 and see that on the 26th of February, this one lady
18 got thirteen prescriptions filled. Thirteen prescriptions.
19 Every one of them was a repeat; every one was authorized
20 on the telephone. Here is another one for Eleven. When
21 you find people getting medication--Dr. Lehmann you
22 might be interested, here is one patient in one month
23 that gets Renese, Tuinal, Thyroid, Achrocidin,
24 Biphetamine 20, Drenison, Lasix, Librium, Premarin,
25 Methedrine, and got them all in one day

26 THE CHAIRMAN: What pharmacy
27 did he like?

28 MR. WILKINSON: Here's another
29 patient: Calcium forte effervescent, Anugesic,
30 Indocid, Valium and Proctosedyl.

1 DR. LEHMANN: That is possible.

2 MR. WILKINSON: That is not
3 too bad. Here is another one that has Valium, Iylenol,
4 Sparine, Butazolidin, Lasix, Ionamin, Kaon, Sparine,
5 Thyroid and Novahistex.

6 DR. LEHMANN: Are these all
7 repeats?

8 MR. WILKINSON: These are all
9 repeats. One of the things that we suspect happens
10 is that a patient will be prescribed a certain sedative
11 and they get a prescription for 30, to take one at
12 bedtime and so they do, and they have difficulty in
13 waking up in the morning, so the next time they go to a
14 doctor, they say, you know, "I'm groggy, I need something
15 to wake up," and so the doctor gives them an amphetamine
16 type to wake her up. And the next time they go they
17 say, "I'm so jittery, I just can't through the day,"
18 so she gets a tranquilizer three times a day. Now she's
19 got sleeping pills, wake-up pills and tranquilizers. So
20 the next time she comes back we find that the doctor
21 says, "that tranquilizer is not working very well; I
22 will try another one". He writes a prescription for
23 another one, and she gets that filled and she gets half
24 way through that and she says, "Well, that wasn't as
25 good as the first one," so she gets the first one
26 refilled and now she takes them both.

27 DR. LEHMANN: But if all
28 doctors are stupid and irresponsible, this assumption
29 would---

30 MR. WILKINSON: This is not

1 an inference. I am pointing out cases as they have
2 actually been pointed to us. I am taking particular
3 cases we have investigated and I am saying this is
4 what happens as a result of this, and that is all I
5 am saying. We want the repeat regulations changed
6 because we say they are ineffective, because they are
7 conducive to all of these abuses. And most of it is
8 not deliberate abuse; it is laxity. It is laxity or
9 a patient taking advantage of a situation as it
10 exists. And to answer Miss Bertrand's question, again,
11 I would say I do not think it would make any difference
12 to the utilization of medication if you just reduced
13 this to one line because this is what is happening now,
14 in effect.

15 PROF. BERTRAND: The real
16 sense of my question was, what proof do we have that
17 the Canadian population using such great quantities of
18 drugs, is worse off?

19 MR. WILKINSON: I can't answer
20 that. I think any time we see a growing social problem,
21 whether it is alcohol or drugs or whether it is any
22 other abuse, I think it is time it was looked into and
23 ^{we would} perhaps/determine that there is really no social
24 problem in prescribed drugs. Perhaps this Committee
25 might decide that. And my judgment would be that
26 there is a problem.

27 MR. STEIN: I think underlying
28 Miss Bertrand's question --- again, this is asking you
29 to step outside of your role, but what do you feel
30 the problem is? Maybe it seems self evident to you,

1 but what is it as you see it or sense it, aside from
2 the fact of use? What is the problem?

3 MR. WILKINSON: It is very
4 difficult. I do not think I have ever looked at it
5 just from that particular cloud, but you have a point
6 there. We are becoming a drug oriented society, and we
7 do have a pill for every ill, and maybe that is good.
8 I have always thought of it as bad. And I guess
9 I have always just accepted it is bad to do this.

10 THE CHAIRMAN: No, you've
11 always felt that non-medical use of drugs is bad, you
12 say?

13 MR. WILKINSON: Yes.

14 MR. CAMPBELL: Would you ---
15 on that particular point --- page 3 of your brief,
16 paragraph 6, "it is necessary of course to draw the
17 distinction between the medical utilization of drugs
18 and the abuses which are really the non-medical use".
19 Could that be taken to imply that non-medical use
20 is inevitably abuse?

21 MR. WILKINSON: No, I do not
22 think we intended this.

23 MR. CAMPBELL: You recognize
24 the legitimate non-medical use of drugs?

25 MR. WILKINSON: Yes. Abuse
26 is such a loose word and it invariably gets people into
27 trouble, and you get all hung up on it every time you
28 talk to the medical profession, because you are
29 immediately challenged on your expertise on abuse.
30 The first thing that you know is that you find that

1 everybody has the same word, but everybody has a
2 different definition for it.

3 THE CHAIRMAN: It would be
4 fair, then, to draw the general conclusion for the
5 purpose of our inquiry, the general conclusion from
6 your evidence this morning, that your present
7 prescription practices, to take repeat prescription
8 practices would appear to be resulting in ^{a diversion of} drugs from
9 medical to non-medical use?

10 MR. WILKINSON: I think that
11 sums it up.

12 THE CHAIRMAN: Are there any
13 other questions or comments?

14 Thank you very much Mr.
15 Wilkinson.

16 We call now on Alderman
17 Bert Weeks, Chairman of Civic Committee on Drugs - The
18 Mayor's Committee.

19 Mr. Weeks?

20 MR. WEEKS: Mr. Chairman,
21 Members of the Commission of Inquiry, I have with me,
22 today, several members of our Civic Committee on Drugs
23 and I would like to introduce them. On my left is
24 Mr. Peter Freel who is attached to the Alcohol
25 and Drug Addiction Foundation. On my right is Mr.
26 Harold Fynn who is the Chief Probation Officer for
27 the County of Essex. On my far left is Mr. Robert
28 Chandler, attached to the University of Windsor faculty.

29 Copies of our brief, I think,
30 have been distributed among the members of the Commission.

1 The introduction is, the Windsor Civic Committee on
2 Drugs was formed more than a year ago to study all
3 aspects of drug use and abuse in the Windsor area. The
4 committee is broadly representative of community
5 interests, including law enforcement, education,
6 medical and parent groups, and social agencies. This
7 brief, dealing particularly with the findings of the
8 Windsor committee on the Windsor situation, is signed
9 by all members of our committee.

10 As one of the first such
11 civic committees in Canada, we recommend that other
12 communities establish similar groups.

13 There is abundant evidence
14 that the use of drugs by youth has reached crisis
15 proportions in Canada. We cannot afford to wait while
16 a substantial part of an entire generation destroys
17 itself. We must use all the corrective means now at
18 our disposal, even though some of them may be imperfect,
19 while continuing the search for better solutions.

20 Your commission is serving
21 a vital function in developing information and focusing
22 public concern on drug problems. But there is a much
23 greater urgency for national action against drug abuse
24 than is generally recognized, and there are areas of
25 action which could and should be acted upon immediately.

26 There are some special problems
27 in other areas such as ours. A number of unique
28 factors characterize the Windsor drug scene because of
29 the city's location on the Canada-United States border
30 close to a very large American city. Specific social

1 research into this geographical drug aspect of the
2 drug scene is needed. In terms of supply, except for
3 marijuana, there appears to be a constant supply of
4 prohibited drugs available in Windsor, probably because
5 of the cross-border traffic. Customs officials are as
6 effective as possible under the circumstances but they are
7 hampered in detecting drug interchange by a shortage
8 of personnel and by difficulties in identifying
9 suspected substances. The supply of marijuana and the
10 quality of available supplies fluctuates widely, in
11 part at least due to the changing supply conditions in
12 the Detroit area.

13 Incentives; mass media
14 influences from the United States are strong in the
15 Windsor area and in general create greater awareness
16 of drugs, their use and abuse. Advertising of over-
17 the counter drugs is heavy. Underground newspapers
18 and radio stations tend to emphasize the drug culture.
19 Both these influences from across the border add to the
20 false glamour and sensationalism of drug use.

21 In law enforcement, cooperation
22 is excellent between enforcement bodies at all levels
23 on both sides of the border. There is a long record
24 of mutual respect and cooperation between local Canadian
25 and American agencies, even during the difficult period
26 of the United States prohibition. In terms of local
27 enforcement, the anti-drug work of both the R.C.M.P.
28 locally and the Windsor Police would benefit from the
29 assignment of additional officers and the special
30 training of all officers for dealing with the type of

1 individual generally involved in drug abuse.

2 Facilities for analysis of
3 suspected materials are inadequate. There is no legal
4 protection in Canada for social agencies who seek to
5 provide analysis. Legislation amendments should be
6 enacted to permit the use of local facilities. In
7 Detroit there is provision for no-questions-asked
8 analysis of materials brought to law enforcement
9 agencies by parents. There is a great lack of
10 uniformity in sentences imposed for drug offences.
11 The differences are notable between different courts
12 in Canada.

13 Among the unique aspects of
14 drug abuse in Windsor, the Windsor area has the same
15 drug abuse problems, in approximately the same intensity
16 as many other large urban centres in Canada. But there
17 are two unique aspects here, and the first is the heavy
18 use of commercial cough syrups, which does not appear
19 to be as common in other areas. Quantities of from two
20 to twelve ounces of the syrup, with or without codeine,
21 are consumed to produce a high caused by the anti
22 histamine content. The second unique aspect of the
23 Windsor drug scene is the comparatively low incidence
24 of the use of foreign substances by injection.
25 Proprietary medicines which contain codeine and anti
26 histamines, that is, Benylin, cold cures, are available
27 without prescription. The quantities in containers are
28 relatively small and, if taken as directed, cause no
29 problems. However, if these proprietary medicines are
30 used in huge quantities by drug users to obtain abnormal

1 effects, this problem should be examined in detail and
2 perhaps referred to a permanent medical and pharmaceuti-
3 cal expert committee consisting of non-civil servants
4 with representatives from all the provinces, operating
5 under the Director-General of Food and Drug Directorate.

6 Amphetamines are being used
7 on a large scale and the supply of these drugs is from
8 illicit sources and from misuse of prescriptions.

9 (We have already heard quite extensively this problem
10 this morning.) Such are issued in good faith by
11 physicians for a variety of conditions. The commission
12 might consider referring the medical use of amphetamines
13 to a medical and pharmaceutical advisory body as
14 referred to in Item No. 13 with a view to limiting the
15 conditions for which amphetamines should be used. For
16 example, this body could examine methods for more
17 stringent control on the manufacture, distribution and
18 prescribing of these drugs if they are to continue to
19 be used medically.

20 Underground drugs; illegal drugs
21 are available on a fluctuating scale of supply, purity
22 and cost in the Windsor area, and the following merit
23 particular attention. Marijuana; availability fluctuates;
24 in times of short supply, alcohol and proprietary drugs
25 are used as substitutes. Hashish, about five times
26 stronger than marijuana, is also available.

27 I have not yet learned to
28 pronounce the full word for THC so I am not going to
29 try, Mr. Chairman. THC is not generally available, due
30 to the intricacies of manufacture. The veterinary

1 anesthetic and other compounds are sometimes sold as
2 THC. There is an increased interest in the use of
3 heroin among young people in Windsor. Cases have been
4 reported as young as a 15 year old girl who has used
5 heroin once. This was reported to our committee some
6 months ago. It is conceivable that there have been
7 other cases subsequent to that time.

8 LSD, the most popular of the
9 hallucinogens, is available in good quality and
10 quantity in the Windsor area.

11 Attempts at finding solutions
12 to drug problems: In Windsor, our committee reports the
13 establishment of a downtown drop-in centre, which was
14 a six-month trial establishment financed by the city
15 and staffed by volunteers and operated under the
16 supervision of the Addiction Research Foundation Staff.
17 Plans are presently under way to continue this in an
18 improved form. Copies of Reports on the Drop-in Centre
19 and the proposed crisis centre are attached. This
20 brief was prepared some two or three months ago. At
21 the time we expected your committee to be here a little
22 sooner than has been the case, and subsequently.
23 proposals for the crisis center will be

24 (portion unrecorded)

25 Students have been exposed to
26 assembly programs intended to discourage them from any
27 curiosity about, or inclination toward narcotics.

28 Recently, new teaching
29 techniques have been involved, aimed at student involve-
30 ment in the learning process, through reports, discussions,

1 buzz sessions, debates, research interviews, and the
2 like, to achieve what teachers were not achieving
3 through the lecture method.

4 The Boards of Education of
5 Windsor have assisted teachers with a wide variety of
6 resources. Courses have been sponsored, workshops and
7 seminars, and teachers have been exposed to psychia-
8 trists, narcotic officers, judges, former drug addicts
9 and former drug users, and films and pamphlets have
10 also been supplied. The Windsor Police Department,
11 with the help of private business have produced an
12 anti-drug film entitled "The Way It Is". The film is
13 being made available to community groups and early
14 indications are that its reception is good and the
15 message from it effective.

16 First attempts at working
17 among youth were made by staff members of the Addiction
18 Research Foundation in individual counselling. As/^{numbers grew}
19 group counselling was adopted. Individuals in the
20 school systems offered themselves as voluntary workers
21 and after training took part in encounter groups.
22 Several of these groups are held in schools during
23 school hours.

24 Cooperation from most social
25 and medical agencies has not been good, perhaps because
26 of already heavy work loads and also because the drug
27 field is so new that therapeutic methods are still
28 experimental. Attempts are continuing to draw other
29 community, social, medical and government agencies into
30 more active participation.

1 Other groups such as service
2 clubs, Home and School, and churches have sponsored
3 programmes to acquaint memberships with the scientific
4 facts. Community groups such as South Windsor Parental
5 Committee on Drugs and the Riverside Committee on a
6 Youth Drop-in Centre have been formed.

7 St. Clair College in coopera-
8 tion with the Addiction Research Foundation offers a
9 12-week course on drug and alcohol dependencies. This
10 course is being repeated periodically.

11 Our recommendations are that
12 greater public understanding of the drug problem, and of
13 individual users, is needed. In the short term, a new
14 attitude must be taken by all social and medical
15 agencies, and in the longer terms, community attitudes
16 toward drugs must be changed to make rehabilitation
17 easier.

18 More use should be made of
19 existing neighbourhood youth centres and drop-in
20 centres; programmes should support non-drug users in
21 order to help them stay clear of the drug culture.
22 New approaches toward working with youth have to be
23 developed with some exclusive focus on personality needs
24 of both drug users and non-drug users. At present most
25 youth programmes seem to place the emphasis on physical
26 sports and this tends to exclude the youth who perhaps
27 are less sport oriented.

28 A permanent medical and phar-
29 maceutical expert committee with non-civil servant
30 representatives from all the provinces, should be
established and this

1 committee would be headed by the Director-General of
2 the Food and Drug Directorate and would advise the
3 Federal Minister of Health on all aspects of drug
4 control and usage.

5 While the local media has been
6 generally cooperative, there is a tendency for sensa-
7 tionalizing the coverage of new fads which appears to
8 increase drug usage, and emphasis should be placed on
9 the positive educational aspect of news coverage.

10 Prescriptions containing
11 barbiturates, tranquilizers and amphetamines should
12 have a notation on the label as to the danger of
13 abuse.

14 Facilities for analysis of
15 suspected materials are inadequate. There is no
16 legal protection in Canada for social agencies which
17 seek to provide analysis. Legislation amendments
18 should be enacted to permit the use of such facilities.
19 In Detroit, there is facilities for no-questions-asked
20 analysis of materials brought to agencies by parents.

21 There is need for more
22 and better counselling service and additional psycholo-
23 gical and social worker assistance. Counsellors are
24 needed in elementary as well as secondary schools.

25 Continuing emphasis on the
26 incompatibilities between a primarily punitive approach
27 toward those who experiment with or become dependent
28 on drugs and modern concepts of treatment and rehabili-
29 tation could lead to further improvement of legislation
30 and enhance the opportunities for the drug-dependent

1 person to obtain treatment.

2 Persistent vigilance by law-
3 enforcement agencies in eliminating illegal sources of
4 drugs needs public support and sufficient means with
5 which to do the job.

6 As recommendations / ^{have} been made
7 to the Government for legalizing the use of marijuana
8 and as the Committee feels that it is not in a
9 position to support this recommendation, the Commission
10 be advised that the Civic Committee on Drugs supports
11 all endeavours made in pursuit of finding the answer
12 to this question. This is submitted by all of the
13 members of our Committee and signed accordingly, Mr.
14 Chairman.

15 THE CHAIRMAN: Thank you
16 very much Mr. Weeks. Would your colleagues like to
17 add any statement at this time?

18 MR. WEEKS: I think they are
19 present mostly to answer any questions which might be
20 directed to them.

21 THE CHAIRMAN: Could we just
22 have a little idea of how this committee was formed
23 and its representative character determined?

24 MR. WEEKS: Well, the committee
25 was formed as the result of the resolution from the
26 City of Windsor Council, Mr. Chairman. A little over
27 a year ago it became quite apparent that drugs were
28 becoming quite increasingly apparent in the community.
29 It was decided that a Civic Committee should be formed, as
30 representative as possible, with a view to try to find

1 some answers to the problem that existed and still does.
2 We have no illusions that there are simple answers to
3 be found, but we have found that public concern on
4 official basis, should be focused on this and every
5 effort made to pinpoint some problems and also to under-
6 take the coordination of agencies within the community
7 that could have some remedial bearing on it.

8 PROF. BERTRAND: Yes, I have
9 three small questions. On your recommendation
10 Paragraph 23, maybe it is only a problem of language for
11 me, but how do you discourage someone from being curious?

12 MR. WEEKS: How can we dis-
13 courage someone from being curious. Would you like to
14 answer that one?

15 MR. CHANDLER: Maybe it is a
16 problem of language for me too. I would say that perhaps
17 one way of discouraging anyone--not just teenagers,
18 but anyone from being curious, would be not to tell them
19 --to take an approach which tells them not to do something.
20 It comes out just with no other position than telling
21 them not to do it, that it is wrong, rather than an
22 educational programme which attempts to give, in an
23 unbiased way, the facts, good and bad, and which helps
24 teenagers make decisions on their own. It has been my
25 experience in working with a small group of these young
26 people referred to at one point in this brief, that if
27 you are able to provide them with facts, with guidance
28 and with your own opinions, but carefully state that you
29 are not trying to force that opinion on them, then, in
30 many cases, they are able to make up their own mind.
But if you say, "don't

1 do it, it's wrong", right away it is sort of like
2 banning books in Boston. It becomes the thing to do

3 THE CHAIRMAN: I understand
4 these are actual programmes that are being referred to,
5 what has actually been done. What in fact has been
6 the nature of these assembly programmes tending to
7 discourage them away?

8 MR. WEEKS: I think probably
9 in 23 the composition is somewhat misleading. I think
10 we probably should have stated rather than curiosity ---
11 to discourage them from an inclination towards experi-
12 mentation of drugs.

13 MR. STEIN: While we are on
14 the question, I am a little bit confused about your
15 stating that the importance is to give people facts,
16 as you stated, good and bad, but you also talk about
17 the necessity for an anti-drug bias in the educational
18 programme. Now which way is it?

19 MR. CHANDLER: No, I did not
20 intend to give that impression in my remarks. What,
21 essentially, I am saying is to give the opportunity for
22 kids themselves --- present the facts, good and bad ---
23 positive and negative. Better still to give them the
24 opportunity to find out these facts for themselves and
25 to present an unbiased picture.

26 MR. STEIN: Let me ask you
27 this. Supposing you were to do this and the decision
28 were to be made by the individual /chose to use one
29 or another drug, would it be your conclusion that he
30 has made the wrong decision?

1 MR. CHANDLER: It would be my
2 personal opinion that he had made the wrong decision. I
3 would not, therefore, castigate him for making that
4 decision. We would go on from there. If I had a
5 relationship with that kid, we would go on from there.

6 MR. STEIN: I'm sorry --- I
7 realize I am interfering, but I just want to pursue
8 this question. Would you be able to indicate what drugs
9 in particular you are referring to, and whether your
10 concern is any use of these drugs or heavy use of these
11 drugs? In other words --- in fact, I'm asking you
12 really, are you in favour of prohibition of all drugs
13 for non-medical reasons? Is this your position?
14 Personally, as we are talking about it.

15 MR. CHANDLER: Yes, personally
16 it is my opinion that if the kid was to make a decision
17 for use of drugs, the strength of my opinion would vary
18 according to the drug, from very strong certainly to
19 heroin and things, to much less strong --- perhaps a
20 weak opinion at the marijuana end of things. I have
21 wrestled with that question in my own mind in the case
22 of marijuana. I don't believe in a hard line approach
23 to marijuana. On the other hand, I am not prepared to
24 join those who say that we should legalize it or even
25 make it available at this point on a controlled basis
26 similar to that of liquor. I suppose I am still on the
27 fence. I hope I know I am on the fence in that
28 way. I have not made up my mind about this. I am
29 struggling about it. My struggles are around my
30 experience, infrequent, with both alcoholism and use of

1 drugs, problems arising from the use of these substances,
2 and I am not sure that we know enough yet to go radically
3 into the direction of even the controlled legal
4 availability of marijuana. If we do, then I think our
5 society needs to be prepared to put a lot of financial
6 resources into new treatment facilities. We have not
7 handled the alcohol problem very well to date. Are we
8 ready to handle another one if we don't know if there
9 is a problem or not here? I have heard that in Morocco
10 they have rather extensive hashish clinics set up. I
11 think we need to look at that. Are we prepared to
12 accept the consequences of the decision? I am not sure
13 we know enough yet about the substance.

14 MR. CAMPBELL: When you said
15 a moment ago about the education programme, you made
16 reference to both good and bad effects of taking
17 various drugs --- let us stay for a moment with
18 marijuana. What would be the good effects that you
19 would include?

20 MR. CHANDLER: I wonder if
21 this --- this is focus on my personal opinion at
22 this time, and I am here as a representative of the
23 committee.

24 MR. CAMPBELL: Is it the
25 committee's opinion that the educational programme
26 should include the good and bad facts?

27 MR. FREEL: I think good and
28 bad might be difficult words to use in this context.
29 I think, again, this is my personal opinion, but we can't
30 argue the fact that certain people find the use of

1 marijuana pleasurable in experience, and that, I would
2 consider to be a good fact if you want to use the word
3 "good". And
4 /certainly we would have to say in any kind of presentation
5 that certain people do definitely find the use of
6 marijuana^a/pleasurable experience.

6 MR. CAMPBELL: Well now, a
7 number of individuals testifying to this commission
8 have gone beyond saying that the use of certain drugs
9 is merely pleasurable. They purported the subjective
10 judgment that they made, that the taking of drugs,
11 cannabis, acid and so on, has been positively beneficial
12 to them --- in reference to the expansion of mind, in
13 reference to greater insight, in reference to improved
14 relationship with other people, in reference to what
15 they claim has been more active perception of themselves.
16 Now this is a very difficult thing to measure scientifi-
17 cally --- what you do is say that that individual
18 reported that subjectively in your facts. Now, do you
19 say that an educational programme should include
20 references to these?

21 MR. FREEL: I think an
22 educational programme must include that side of the
23 question. Equally, there is probably --- certainly not
24 with
25 cannabis, but definitely with the heavier hallucino-
26 gens, I think you would have to say that there are as
27 many people who have reported the opposite effects, and
28 I think in this case you would have to say ---

28 THE CHAIRMAN: Gentleman at
29 the microphone?

30 THE PUBLIC: Are there any

1 youth on the planning session your committee?

2 MR. FREEL: We have had
3 regular attendance from the school system. From last
4 year up until June, there were two premanent representa-
5 tives from the schools and we have had attendance at
6 one of the meetings since September of this year. I
7 think there have been about five meetings and of that
8 number, we have had attendance at one as representative.

9 THE PUBLIC: Have they been
10 invited or what is the procedure?

11 MR. FREEL: They were invited.
12 The people were contacted through the school representa-
13 tives--through the representatives of the Board of
14 Education, and once case included a former user.

15 THE PUBLIC: To what extent
16 has probation been used in the City?

17 MR. FYNN: Very slightly ---
18 I think this question has to be expanded on. Your
19 question has to do largely with law enforcement and
20 how effective are the police in arresting people who
21 are involved with illegal drug abuse. They are being
22 brought before the court; they are being found guilty
23 of an Offence under these Sections of the Code or other
24 Acts, and the decision of the judge that probation is
25 the proper way of dealing with this particular case.
26 We do not have large numbers of people on probation
27 at the present time for drug abuse offences, for the
28 simple reason that large numbers are not being arrested
29 and brought before the courts and convicted.
30

1 THE PUBLIC: And those that
2 are arrested, what is the disposition of the court?

3 MR. FYNN: Well, there are
4 varieties of disposition from imprisonment to fines,
5 through probation.

6 THE PUBLIC: Can you see any
7 effectiveness in imprisonment?

8 MR. FYNN: I see no alternative
9 for the pusher. I distinguish quite clearly between
10 the pusher and the user. If we have no pushers, well
11 then, we will obviously have many fewer users. The
12 illegal distribution of drugs depends upon the pusher.
13 We have, I think, very serious problem here to be dealt
14 with. Previously, we only had to consider the
15 heroin addict. Let's address ourself to the situation
16 ten years ago. These people were not the most desirable
17 members of our society; they were usually, constitutionally
18 and from the personality point of view, they were weak
19 people. Had they not become narcotics ^{they} would probably have
20 become hung up on something else. This is not the case
21 with the present situation where we have a wide variety
22 of choice in illegal drugs that we might use, and the
23 pusher may well be a young, clean-cut, middle-class
24 high school student, who knows what he is doing, who is
25 enjoying the high profitability of his "profession," if you
26 might call it that. Well then, if he is enjoying the
27 profitability of his activities, well then if he is
28 arrested, if he is found guilty, well then he should
29 also realize that he faces a very, very good possibility
30 of a very, very hard sentence.

1 MR. STEIN: Do you make any
2 distinction on this point about pushing and trafficking?
3 Do you see any necessity for making any distinction in
4 relation to traffickers, for example, as you would
5 indicate persons in high school may be
6 ---portion inaudible
7 by some people that it is very hard to find any users
8 for some of the drugs that are concerned --- that young
9 people are using, any users that are not technically
10 traffickers as the law now describes it, because the
11 gift, as it were, of a single cigarette of marijuana to
12 another individual technically qualifies the individual
13 to be charged in the courts as a trafficker. So my
14 question is, do you have any concern about the present
15 trafficking laws? Do you see any need for modifying
16 them, or do you think they are adequate and do you
17 want to make any differentiation?

18 MR. FYNN: I take a black
19 letter attitude. The law is the law. The law has been
20 laid down by Parliament, it is enforced by the police.
21 The assumption is, the law is not wrong and the
22 consequences of breaking the law is known to all.

23 MR. STEIN: So that a gift
24 as it is now described as trafficking from one party
25 to the other, you would be satisfied to see this remain
26 in the same category as, say, that other person selling
27 heroin for a high profit?

28 MR. FYNN: Yes, one sees the
29 wisdom of the judges in handling these cases and the
30 judges do plenty --- these are my personal opinions but

1 --- I speak now for the bunch out here --- see the
2 differentiation here. They do differentiate clearly
3 between the possession or the pushing of one marijuana
4 cigarette, and the possession and pushing of drugs
5 and narcotics and conduct themselves accordingly.

6 MR. STEIN: You mentioned
7 in your committee's brief your concern about the
8 different ---

9 MR. WEEKS: Excuse me, we
10 may have a slight difference of opinion among members
11 of the committee, if you would like to hear another
12 version.

13 MR. FREEL: My personal
14 feeling is one of the problems we find particularly in
15 the treatment area and one of the problems that is
16 particularly confounding in the youth drug scene is
17 the fact that you have stated that a large number of
18 people who are involved in the drug scene are involved
19 in this kind of trafficking and I think there has to be
20 a very definite legal distinction in terms of any kind
21 of rehabilitation potential. We have frequently found
22 in our treatment programme, for example, where we have
23 dealt with people where we knew even to the point of,
24 let's say, trafficking for money, that it is easier to
25 work on that kind of a situation and get him to stop
26 doing that, be it over a long period of time; it
27 is not something that takes place overnight. But I
28 think that most people are certainly aware of the risks
29 and when someone deliberately enters into the risk for
30 a substantial amount of profit and is trafficking in

1 large quantities, I would definitely say that the law
2 should be very severe in this case. In the case that
3 you quoted where you were talking about somebody giving
4 somebody a marijuana cigarette or a tab of acid, I think
5 that there, I think a different legal approach should
6 be taken. Furthermore, I think this is one of the areas
7 in the educational process. Despite the arguments
8 advanced by very many users, it is possible to give your
9 girl friend a tab of acid and it can be a very dangerous
10 type of business. You don't know what is going to happen.
11 And I think the more we put this across to people that
12 what you do to yourself is one thing, but when you start
13 to turn other people on you are taking a responsibility
14 on yourself that you must be well aware of. I would
15 much rather see a definite distinction legally, somehow
16 made, and I am not a ^{lawyer} and I wouldn't want to get
17 into the technicalities of this.

18 THE PUBLIC: One final question
19 to the Chief Probation Officer, is the official policy
20 of the Essex County Probation Service in a presentence
21 report to recommend sentencing for trafficking?

22 MR. FYNN: No, this is a
23 requirement in the American courts. We do not recommend
24 --- do not make recommendations in the presentence report
25 at all. The Canadian point of view is that this is
26 usurping the judicial function. The judge in the sentenc-
27 ing process may reach for the assistance of anyone who
28 can help him and may ask the Probation Officer verbally
29 or may ask the solicitor or may ask the psychiatrist
30 whether or not this would be the better way of dealing

1 with this particular person. But as far as the printed
2 document is concerned, we very rarely make recommenda-
3 tions of this kind. We let the facts of the reports
4 speak for themselves.

5 THE CHAIRMAN: Professor
6 Bertrand, you had two other questions.

7 PROF. BERTRAND: Yes, the
8 other question was with respect to Paragraph 26. You
9 mentioned that a film was made with the help of private
10 business and I would have liked to know what sort
11 of business was interested in this drug thing, and also
12 I would like to know how a film could be titled "The
13 Way It Is" if it is (expressing a negative viewpoint).

14 MR. WEEKS: In response to the
15 first part of your question, the film was commenced
16 through contributions from local commercial establishments.
17 I think the purpose of the film was simply to describe
18 the way the drug scene is. How adequately this was
19 achieved, I am not prepared to say.

20 MR. FYNN: The film has many
21 positive aspects. The film is completely negative as
22 far as the use of drugs are concerned.

23 PROF. BERTRAND: I see.

24 MR. STEIN: Well, on that
25 point, and interrupting my colleague again, at the
26 risk of grave danger,
27 we have been told at numerous times that one of the
28 most practical ways to approach the phenomenon of
29 educating people around this question, and in the earlier
30 comments you seem to agree with this, you seem to present

1 what essentially is a negative picture on the grounds
2 that any attempt by the party presenting this negative
3 picture to give accurate information will then be ---
4 well, his credibility in effect will be non-existent
5 and it may be more harmful than if he had said nothing,
6 because even accurate information may be disregarded.

7 I mean, do you --- you see,
8 you seem to feel that this drug film has had some
9 positive effects or it has had some positive potential.
10 Would you not share this general concern as it has been
11 expressed to us about the dangers of almost as strong
12 reaction, as it were, when one presents just the straight
13 negative bias, or do you feel it is an effective way
14 to educate?

15 MR. FREEL: I think really,
16 you would have to see the film in order to make a
17 judgment as to the extent to which it is anti drug.
18 What they do in the movie is, essentially, present what
19 happens to people who have the adverse reactions. There
20 is no editorial comment, "you are on the road to hell,
21 if you take drugs," that is not the approach that is
22 taken in the film. It is a succession of incidents in
23 which various individuals have very negative reactions
24 to drug use.

25 DR. LEHMANN: Is it stated
26 that the adverse reactions are ^aminority?

27 MR. FREEL: No, there is no
28 comment made that way, and the response to the film has
29 been highly ambivalent depending even among all --- just
30 about every group. We have shown it when it was first

1 produced to a group of people that we had in a group
2 programme in our agency and we felt that it was
3 excellently done, and another group saw the film from
4 the same agency and they felt it was terrible. We get
5 various types of reactions on both sides. To pursue
6 this other point on the whole area of education, and
7 this is being discussed very extensively at this point
8 now on our committee at the Board of Education, there
9 is a general feeling among the students, particularly,
10 that this whole drug education question has reached the
11 saturation point. It is being dealt with in other
12 cases out of context to different courses where it has
13 no proper place, and there is definite effort now being
14 put to balance this in this drug education in the light
15 of other education related to alcohol, nicotine and
16 other health problems in the health curriculum where it
17 is supposed to be in the Province of Ontario. And we
18 feel now, I think, as a committee, pretty definitely,
19 that we have to take a pretty hard look at some of the
20 educational approaches, even to the point of communicating
21 facts, that this has to be balanced out and that we have
22 gone too far away in the other direction in trying to
23 counter this thing, and the students are in so many
24 films, in so many discussions, the very thought of having
25 another one is enough to turn most of them off.

26 PROF. BERTRAND: My last
27 question has to do with Paragraph 34; I don't understand
28 why the non-civil servant representatives have to be
29 guided by the Director-General. I don't really under-
30 stand the structure and the functioning.

1 MR. FREEL: This is the
2 recommendation that was made by our local Health Unit
3 specifically, and I think the feeling there is that
4 there needs to be a representative group of different
5 professional groups across the country that have
6 concern with the area of drug abuse that goes beyond
7 this type of concern --- perhaps something like your
8 commission that is regularly reviewing on a broadly
9 representative basis a lot of these questions that
10 could provide some import to this.

11 PROF. BERTRAND: And why
12 the guidance by the Director-General?

13 MR. FREEL: I suspect in
14 that sense technical, and if you are putting in an
15 organization, this is where this should be, organization.
16 But the definite type of feeling is that a continuing
17 review of the whole question of drug control and use
18 should be undertaken and be representative of a much
19 broader segment of the Canadian population, of professional
20 groups and so forth, in concern with this problem.

21 MR. CAMPBELL: Mr. Weeks, I
22 would like to question four items in this brief. Section
23 13, you are speaking of the unique aspects of drug use
24 in Windsor, referring to high levels of use of cough
25 syrups and of injection. I would like to know the basis
26 of your information about the level of use and the
27 basis upon which the statement of relevant use, presuming
28 vis a vis other parts of Canada has made.

29 MR. FREEL: It has been our
30 experience in connection with the particular use of

1 one brand of cough syrup that is mentioned in the brief,
2 in contacting other people in other parts of Ontario and
3 the people who are working in this field, that this is
4 a relatively insignificant kind of phenomena that takes
5 place essentially with the young abusers whereas here,
6 we find it to be pretty well --- this afternoon you will
7 hear a brief relating to this study and there will be
8 some statistics and this drug comes out, I believe,
9 number three, after marijuana and LSD among the people
10 in this community. And we have had a problem with this
11 to the extent that this particular brand of cough syrup
12 has been removed and put under the pharmacist's control
13 in all the pharmacies of Essex County through the Essex
14 County Pharmacy Association, as well as a couple of
15 other substances relating to travel sickness.

16 MR. CAMPBELL: Gravol among
17 this?

18 MR. FREEL: Yes.

19 MR. CAMPBELL: What about
20 Romilar?

21 MR. FREEL: They seem to have
22 one particular brand discovered this/and stick to it. It is sold in
23 three forms. One with codeine, one without, one which
24 is (Doridan) which is a cough supressant, and the
25 codeine substance, when that was controlled, put behind--
26 the pharmacist tightened up their own control, we found
27 them switching to the substances such as (Doridan) and this,
28 they don't seem to have discovered other such things as
29 Nyquil, Romilar. They seem to stick pretty well with
30 the one brand.

1 MR. CAMPBELL: In Section 16
2 in reference to the underground drugs, you say that
3 marijuana availability fluctuates. In times of short
4 supply, alcohol and a variety of drugs are used as
5 substitutes. The assertion has been made to us, I
6 suppose very frequently, that in other parts of Canada
7 when there is a shortage of marijuana, there has been
8 a marked tendency for use of LSD to increase sharply.
9 I was struck by the fact that in your opinion here it
10 diverges from the opinion that has been expressed so
11 frequently elsewhere. Have you found a relationship
12 between availability of cannabis and use of acid?

13 MR. FREEL: Use of chemicals
14 I think, definitely increased last summer and during the
15 fall, and of course that is when the major marijuana
16 shortage existed. We would have found, I think, more
17 from experience that people here, at least during the
18 last year, were going through a temporary disenchantment
19 with LSD. One rather interesting thing, I think,
20 encountered in the drug scene here is the fact that we
21 have relatively few methamphetamine users. We have seen,
22 I think, in our office no more than a half a dozen
23 people who have had any kind of serious problems relating
24 to the use of speed whereas in other cities like London,
25 it is probably the main drug problem that they have. Now
26 we feel that we may be developing one here. There are
27 signs showing up now that there are more people showing
28 interest in speed, but to this point of time our main
29 problem in terms of the injectable drug has been heroin.

30 THE CHAIRMAN: Gentleman at

1 the microphone?

2 THE PUBLIC: I would like to
3 ask a very brief question. Has the committee addressed
4 itself to methods of determining the magnitude of the
5 problem and is there such a procedure that has been
6 attempted, and is fairly reliable?

7 MR. WEEKS: We don't have any
8 means to determine --- to make this determination in
9 Windsor. We are dependent on information that we see
10 from members of the committee who are representative of
11 the local scene.

12 THE PUBLIC: Is this assessed
13 on some sort of trend? I wonder if Mr. Freel has any
14 knowledge of a trend in this regard.

15 MR. FREEL: I think that the
16 statistics is a very difficult sort of business.
17 We would suspect that it is increasing --- whether it is
18 increasing in terms of more usage or more visible,
19 would be the difficult thing to determine. Certainly,
20 as we are all aware, there are ^{more} problems occurring in
21 school and there seem to be more people aware at the
22 neighbourhood level, there are more people aware that
23 in certain community agencies, it is touching more. Yet
24 when you come down to the hard statistics of adverse
25 reactions, you find the hospitals here in the city
26 turning up about one a week in the hospital who have
27 adverse reaction on LSD or other drugs. This is
28 excluding overdose situations of barbiturates. So I
29 think we would generally say some kind of an increase
30 or where or how much is really difficult to determine.

1 I think making these ball park guesses to try to come
2 up with that, or try to base any conclusions as to
3 what we could do about the problem or the extent of it,
4 I think we have enough evidence now and certainly this
5 is the position that the committee has taken from the
6 beginning, that we were not interested in running a
7 survey or doing a head count to find out if it was a
8 problem. There were enough people reporting that it
9 was a problem for some individuals, to feel that some
10 action should be taken by the agencies in the committee.

11 THE CHAIRMAN: Gentleman at
12 the microphone?

13 THE PUBLIC: Mr. Chairman and
14 members of the committee, I would like to address you
15 on behalf of ... (portion inaudible) I am a lawyer in
16 the city and I am not a drug user, but being a lawyer
17 I am concerned with the press reports that are made as
18 a result of certain charges against young people. I
19 have in mind a case which is subjudica and I am not going
20 to speak of it in particular. Apparently the newspapers
21 and the CBC carried reports of two young people who were
22 both going to high school, charged with trafficking and
23 intimated that a 13 year old girl was involved. In
24 other words, trafficking---13 year old girl, trafficking
25 and a 13 year old girl using the drug. Now the report of
26 a 13 year old girl, apparently came from somebody's files,
27 not in the Crown Attorney's Office. But for the press
28 and the newspapers to use, this information, pretrial,
29 together with the names and addresses of these young
30 people, is, I submit,

1 not only incapable but most irregular. Now these young
2 people are actually being punished twice. They are
3 being punished through public opinion when they are
4 charged, and they are getting publicity in the newspaper
5 without a conviction --- purely a charge which may have
6 no basis at all, in fact. They are being punished in
7 the newspaper and subsequently punished in the courts.
8 This is most unfair. Now the newspapers have had an
9 admirable practice in the past of restraining publication
10 of young peoples involved in offences, and of course
11 that is required under the Juvenile Delinquents Act.
12 But I do suggest this, I think they could withhold,
13 surely out of pure decency, the names and the addresses
14 of these young people who are charged. If they are
15 convicted, fine, it might be fair comment in the public
16 interest, but until they are convicted, they are doing
17 a great injustice to these young people. These young
18 kids are going to high school, and friends and acquaintances
19 subject them to a great deal of criticism and these
20 charges have not yet been proven, and it is a responsible
21 public duty in that community. The newspapers are very
22 reprehensible I submit, and they should be stopped.

23 THE CHAIRMAN: Thank you.

24 Gentleman at the microphone?

25 THE PUBLIC: I think I could
26 sort of explain that question a little bit. The fact
27 that Mr. Weeks has assumed that the drug problem has
28 reached crisis proportions, it sort of follows up the
29 assumption that the newspapers are extending this thing
30 about convictions to the point where they are making it

1 a real public issue and I would ask Mr. Weeks what the
2 evidence is now that he could make such a statement that
3 it has reached a crisis situation, and how the newspapers
4 have been guilty of extending that problem.

5 MR. WEEKS: Well, as Mr. Freel
6 has already stated, there hasn't been much in the way
7 of statistical records in the whole area, but there
8 certainly does seem to be abundant evidence that the drug
9 culture has vastly accelerated in the last several years,
10 and certainly from the information that is made available
11 to our committee, that would appear to be the case on
12 the local scene.

13 THE PUBLIC: What kind of
14 evidence do you have? It is very easy to say it is a
15 crisis.

16 MR. WEEKS: Amongst other things
17 for example as mentioned earlier, we have representatives
18 from the student bodies of the various schools. Some of
19 them have been on drugs themselves, informing our
20 committee of extended drug use in the various schools.

21 MR. FYNN: Added to that of
22 course is that the school guidance system has approved--
23 both the public and separate schools who are on the
24 committee, and they give some idea of the incidence of
25 drug usage in the schools and the number of people who
26 come to or are referred to the Alcoholic Research Founda-
27 tion, the indications that became apparent to us while
28 the drop-in centre was in operation in Windsor. And
29 these are the ways in which we form our impressions. In
30 all honesty, we can not give you numbers and we feel that

1 this problem has reached critical proportions because
2 I think we are comparing what we see now through these
3 avenues of information, to what was happening eighteen
4 months or two years ago, where it does seem that there is
5 a noticeable increase. But if you want me to give you
6 slide rule measurements, I don't think I can and neither
7 can the committee. It is an illegal activity and people
8 are most careful to cover up what they are attempting
9 to do.

10 THE PUBLIC: The thing that
11 bothers me is you have made some kind of an assumption
12 that the increased use of drugs can be related directly
13 to abuse of drugs and it seems to me that that is quite
14 a value judgment to make. Especially, and it seems quite
15 apparent that you haven't presented very much evidence
16 and especially since you didn't seem to have too many
17 young people on the panel of your investigating committee,
18 and it sort of bothers me.

19 MR. FREEL: I would like to add
20 a couple of points to that. First of all just to give
21 you an indication of the kind of indices we would use in
22 determining whether or not it is a growing problem. Two
23 and a half years ago the Addiction Research Foundation
24 in Windsor was unaware of any significant drug involve-
25 ment on the part of the young people in the community.
26 A year and a half ago--two years ago we started to
27 become aware of it, about two years ago now, and the
28 numbers of individuals that we have come in contact with
29 casually and so forth has steadily increased during that
30 time. The second thing is the fact, if you like, of

1 hospital admissions. In the last month we have had a
2 substantial increase in the number of admissions to
3 psychiatric hospitals as a result of adverse drug re-
4 actions, or reactions that have been precipitated by the
5 use of drugs.

6 THE PUBLIC: But is it the users
7 themselves that are putting themselves in hospital or is
8 it people like you who are telling them they have a real
9 problem, and, you know, send them to these institutions?

10 MR. FREEL: I think when you
11 get people coming and saying to you, you know, I need
12 to go into the hospital because I am having recurrences,
13 I think that the inside of my head is caving in, and
14 when that happens, I pass out, and was found out on the
15 lawn of the neighbour the next morning. Another person
16 flies from Toronto, who is diagnosed as paranoid-
17 schizophrenic and wants admission to the hospital, then
18 this is pretty tangible evidence of the user saying,
19 "help me", and I could give you more examples like that.

20 THE PUBLIC: It is just this
21 thing when you use the words "diagnosed as". Something
22 really bothered me in drug terms, you know. Very quickly
23 we will label the person as having a certain problem and
24 that problem becoming a personal crisis, and you know
25 it is very easy for a person to accept that kind of a
26 judgment from a professional, you know, especially when
27 he doesn't have the information about the drugs, but it
28 can be a real problem if we are telling these people
29 that they are sick or something and, you know, then
30 there is really no way of knowing whether it is a real

1 problem. We make a problem more of them.

2 MR. FREEL: In one case I
3 think it is clearly an adverse reaction to a drug and
4 the second case, I suspect this may be some sort of
5 pre-existing condition that was exaggerated use of LSD
6 for a week. Now the point is, he was well down from
7 the drug when he arrived here, on this one case I am
8 referring to. Now the point I am making is that when
9 somebody comes to you and says, "help me," then you have
10 got to sort of make some sort of a judgment on that
11 basis. Now whether he thinks it is induced by drugs or
12 whether we want to hang 27 different kinds of labels on
13 it, is quite irrelevant to the fact that he is asking
14 you for his help, and those are the terms under which we
15 see people. We don't go around with a net of some sort,
16 you know, scraping up people that we think have a drug
17 problem. We wait too --- if somebody wants to come to
18 us it is strictly voluntary.

19 THE PUBLIC: I see the type
20 of approach, it is just that when a person comes and
21 asks for help and you tell them that he is sick, I don't
22 think that is the best way to help him, to put him in an
23 institution.

24 MR. FREEL: If that is what he
25 wants, then ---

26 THE PUBLIC: That is, he doesn't
27 know what he wants because that is the reason he is on
28 drugs in many cases.

29 MR. FREEL: I think you can't
30 make judgments like that. You have to judge the cir-

1 | cumstances of every case and one of the circumstances we
2 | are trying to make here, and one of the ones the
3 | committee has come into grips with is, we have to try to
4 | get the agencies and the services in town oriented to
5 | the point, if you will, they are able to handle the
6 | individual problem of the individual drug user, or the
7 | individual anybody presents, and very often this is not
8 | the case.

9 | MR. CHANDLER: I think the
10 | point this speaker is making in his question is a good
11 | one that needs to be emphasized here to treatment
12 | professionals. It is very easy for the professional
13 | person to define a problem and overlook the need for
14 | participation of the person himself in defining what the
15 | problem is. I think this speaker has brought this out
16 | and I think Mr. Freel has responded to it in this way,
17 | that this has been our approach through the Addiction
18 | Research Foundation, that the person who comes in very
19 | definitely is a participant --- a partner, if you want, in
20 | the definition of the problem, and I would agree with
21 | you that this is extremely important. It is very easy
22 | for a person to become sick just because somebody else
23 | defines him as sick.

24 | DR. LEHMANN: I would just ask
25 | one question to clarify this. Would you say then that
26 | if somebody comes and asks for help and says, "I am sick"
27 | number one he would say, "I am distressed", second he
28 | would say, "I am sick". Secondly he would say, "I want
29 | to go to the hospital." Then somebody should have the
30 | responsibility to say, "You shouldn't go to the hospital

1 and you are not sick. We will help you the way we think
2 it is all right and not the way you think it is all
3 right."

4 THE PUBLIC: I think really
5 the optimal situation and the best type of situation would
6 have that person talk to people who he thinks understand
7 him.

8 DR. LEHMANN: That is why he
9 came for help.

10 THE PUBLIC: But the problem
11 is, like because there is nobody else he can go to for
12 help to. He can't talk to his parents, he can't talk
13 to the people in the schools. There aren't enough of
14 these kind of problem centres where you go to get this
15 kind of assistance, especially the kind of moral
16 assistance he needs.

17 DR. LEHMANN: You feel he is
18 forced to go to whatever there is. A lesser evil, that
19 is not the best.

20 THE PUBLIC: He has not the
21 choice very often, and that is the real problem. And
22 he has to also sort of go through this situation where
23 he is almost under interrogation, "why do you do it,
24 what were the situations?"and he is intimidated by that,
25 he is afraid to start with, you know, which is one of
26 the reasons, you know, he may use drugs in a bad way.
27 But then when he gets into a situation, he is just
28 almost like under fire, you know, using drugs and he is
29 really in a double bind, because no matter which way he
30 turns, he is afraid and he is bound to try and escape

1 even more. And I think that, you know, the problem is
2 going to get much bigger, if we don't, you know, come
3 to grips with that problem. You know, the whole thing ---
4 you know, you are talking about the non-medical use of
5 drugs and yet so many of the solutions we propose are
6 kind of very medical, or very kind of official and a
7 young person, you know, who is on the drugs just can't
8 relate to that kind of a, you know, perspective of drugs
9 which is perhaps the reason that there aren't too many
10 young people at the hearing this morning. You know, it
11 is a very medical, kind of very formalistic kind of
12 approach, and if people who are taking the drugs are
13 trying to get away from that, I don't think you can get
14 much response from young people if, again, you know,
15 you are sitting like this on a panel and, you know,
16 people just can't relate to you.

17 DR. LEHMANN: Just because of its
18 structure?

19 THE PUBLIC: It is not just
20 the structure, it is the whole way you are approaching
21 it as a problem, and equating use and abuse, and the
22 same thing, it is a "crisis situation." You know, a lot
23 of young people, you know, just say it is nonsense and
24 they won't even try to talk to you about it.

25 MR. FYNN: When you say the
26 crisis situation is nonsense or ---

27 THE PUBLIC: I am not saying
28 that, I am saying a lot of people think it is nonsense
29 because they have tried to get the drug, and they see
30 a film like "The Way It Is", I haven't seen it yet, but

1 you just assume, okay, you take a negative approach to
2 it. The kids can see through that. You know, they
3 have tried drugs and it is pleasurable, as you said,
4 you know, and even if they see a film like that and
5 that is hypocisy, you know, you are not presenting
6 the other side of the situation and yet in the schools,
7 you know, you are telling us, "look at both sides of the
8 problem, and you are not. You know, you just assume it
9 is a crisis and you assume that use is abuse, and,
10 well, that is not going to solve the problem.

11 DR. LEHMANN: Do you accept
12 a certain amount of structure? For instance, you pay
13 for drugs, somebody will go and buy a certain amount
14 for somebody else. And there is structure involved
15 there. Now in a crisis situation, there is very often
16 a structure needed in order to deal with a crisis
17 and that may be a prescribed procedure which may be
18 stereo typed but simply it is because it is a crisis,
19 requires structure but because it is structure, no, it
20 must be the wrong treatment.

21 THE PUBLIC: Of course you
22 have to have some sort of a structure, I am not saying
23 let's do away with it, but the problem is you have to
24 face up to the fact that this is one of the reasons kids
25 are going into drugs. They are reacting against
26 an excessively structured educational system, you know,
27 excessive structure in just about everything they have
28 ever tried to do in their lives, and you know, you have
29 to come up with some kind of an alternative and maybe
30 through the treatment that is the kind of alternative

1 you can have. I don't have the answers, I am just
2 raising the questions for you to consider.

3 THE CHAIRMAN: But you are
4 familiar with adverse drug effects?

5 THE PUBLIC: Yes.

6 THE CHAIRMAN: You recognize
7 their existence?

8 THE PUBLIC: Yes, Mr. Chairman.

9 THE CHAIRMAN: And you recog-
10 nize the existence of adverse drug effects calling for
11 specialized medical treatment?

12 THE PUBLIC: Yes.

13 THE CHAIRMAN: And calling for
14 hospital facilities and fairly technical and well
15 organized character. They just can't be picked up
16 anywhere on the streets, I mean they have to be
17 localized to some extent.

18 THE PUBLIC: Yes, I recognize
19 that.

20 THE CHAIRMAN: And you would
21 recognize --- and you would ^Ipresume --- recognize the
22 responsibility of society to attempt to help someone,
23 medically help someone who would be suffering from such
24 adverse effects, responsibility of the society to supply
25 those medical resources to the aid of that person,
26 wouldn't you?

27 THE PUBLIC: Yes.

28 THE CHAIRMAN: And so you
29 would have to agree that the physicians and those in
30 charge of those resources would have to be the judge of

1 how those resources are to be applied and they would
2 have to be the judge of their own procedures. I don't
3 mean without criticism, I don't mean without review, I
4 don't mean they are immune, but at the end of the day
5 if they are to accept the responsibility for serious
6 adverse effects in a crisis situation, they have to
7 know how those facilities are best used. Would you
8 agree with that?

9 THE PUBLIC: I would agree
10 with it, yes, but the whole question of judging ---
11 like that again is an intimidating kind of term.

12 THE CHAIRMAN: I simply said
13 they shouldn't be free of criticism of their methods,
14 I didn't mean to say they were immune from judgment.
15 That wasn't in the context I used the word judgment,
16 but at the moment you would concede that they had to
17 be --- the physician has to be the judge at that moment
18 of how he must use his facilities?

19 THE PUBLIC: Right; right.
20 That is true. But the judgment has to be also, you
21 know, include a kind of a judgment of his own methods
22 that he is using, the kind of a judgment of facilities
23 so he can improve them and that is, I think, where we
24 are maybe hung up now. I have talked to a lot of
25 psychologists who have tried to treat people on drugs
26 and they assume --- okay, this thing again about this
27 problem of use and abuse, all of that, and they assume
28 that some of the treatment they are using is the best
29 we have so we are just going to use that now, and ---
30 not enough questioning of that kind of method. I will

1 give you an example, last year. I have a very good
2 friend who was committed to the Ontario Hospital in
3 Toronto and he went through this shock treatment, you
4 know, it is a very, very complicated kind of procedure,
5 but he came out of it worse than he had gone in, like,
6 because what they did, they showed slides of a person,
7 you know, dropping say a tab of acid, and every time
8 that one of those slides would come on to the screen, he
9 would get a shock. Okay, so trying to induce him not to
10 take acid because he would get a shock. So what
11 happened, when he got out --- when he got out of that
12 treatment, every time he wanted to take, you know, a
13 tab of acid he really experiences a sort of a double
14 shock, you know, like he knew that maybe it wasn't
15 going to be a good thing for him, but he also had this
16 fear that he was going to get a shock, so this treatment,
17 you know, sort of made him doubly paranoid about the
18 whole problem, and about the problem he had of drugs.
19 It was just that kind of example I was stating was a
20 bad thing.

21 THE CHAIRMAN: That was
22 presumably the object of the treatment, wasn't it?
23 Did he voluntarily accept the treatment?

24 THE PUBLIC: No.

25 THE CHAIRMAN: Did he know what
26 the object of the treatment was?

27 THE PUBLIC: He didn't, no.

28 DR. LEHMANN: That is behaviour
29 therapy, it is hardly possible to give him behaviour
30 therapy if he doesn't cooperate and accept it voluntarily.

1 THE PUBLIC: The thing is he
2 realized --- okay, the problem was he realized, you know,
3 he was having psychological problems because of the
4 drugs he had used, so he didn't know enough about the
5 kind of therapy that, you know, might have been applied
6 to help him, so he again, this question of someone
7 telling him he was sick, and you know, he assumed that
8 that was the best way to have himself treated, and he
9 didn't realize of course beforehand that these after
10 effects might occur. Nobody told him that there was a
11 chance that he was going to have these after effects,
12 which he definitely had.

13 THE CHAIRMAN: But what
14 precisely was he treated for? What did he want to be
15 treated for?

16 THE PUBLIC: Okay, well he
17 had feelings you know. He felt totally alienated and
18 nothing meant anything to him any more. It was a very
19 big kind of problem that he felt, that a lot of others
20 must feel too, and so he wanted to, you know, make the
21 external world feel more real to him. So he went in
22 and talked to a Dr. Bill Clement whom you might know,
23 at the hospital in Toronto, and I have talked to him
24 personally, and his methods just don't seem right. So
25 he went ahead with this treatment without even explaining
26 to him what the possible consequences might be, and
27 this friend came out much, much worse than he had been
28 before. He felt this double estrangement. Now that is
29 one particular example. I don't want to make any
30 general conclusions about it, but it is again raising

1 the question about this kind of treatment. There are
2 people using drugs, and does this usually help or does
3 it make it more of a crisis?

4 THE CHAIRMAN: Did he not
5 go in for some effect attributable to LSD? He did go
6 in for some effect attributable to LSD?

7 THE PUBLIC: He thought it was.

8 THE CHAIRMAN: He though it
9 was.

10 THE PUBLIC: Yes, but the
11 actual thought and the actual reality is not always as
12 close as that.

13 THE CHAIRMAN: And he didn't
14 really want to be cured of any desire for LSD?

15 THE PUBLIC: No, he really
16 wanted to be, well not the word cured ---

17 THE CHAIRMAN: No, I was
18 trying to stress it, but he didn't ask, like, "look, I'm
19 afraid of LSD, I don't want to have anything more to do
20 with it, will you arrange things so that I will no
21 longer have any inclination to use it?" He did not
22 clearly have that desire?

23 THE PUBLIC: No, it was not
24 that specific, it was the effect which he considered.

25 THE CHAIRMAN: So in a sense
26 you are suggesting this is an involuntary treatment?

27 THE PUBLIC: Yes, it was the
28 voluntary desire to have this alienation cured, or
29 whatever word you want to use, but it was involuntary
30 submission to this kind of treatment, because he did not

1 understand what the possible consequences might be.

2 THE CHAIRMAN: Thank you. I
3 have just had a suggestion that we are getting close to
4 the hour for lunch, and there are some signs of rest-
5 lessness at the other table ---

6 THE PUBLIC: Mr. Chairman, may
7 I just hold up the Commission for just one moment,
8 because there is one question I want to ask the
9 Commission. It is simple, but it is not easy. I am
10 having problems trying to decide what drugs you are
11 talking about, the difference between medical use and
12 non-medical use and whether you are discussing the use
13 of drugs or the abuse^{of} drugs. Could you clarify that for
14 me please, because I see some people all over the room
15 using drugs this morning, tobacco. I have got the
16 yellow sheet, but it seems to me that cigarettes are
17 tranquilizers and I have not heard alcohol mentioned or
18 aspirin tablets. It seems we are zeroing in on whatever
19 the kids are doing.

20 THE CHAIRMAN: I am sorry, I
21 have lost track of the question.

22 THE PUBLIC: Well, there are
23 certain drugs that are not mentioned, and I want to
24 know what drugs you are talking about, whether we are
25 discussing medical using, non-medical use, how you
26 arrive at the difference and whether you are talking
27 about abuse?

28 THE CHAIRMAN: Were you not
29 here when we read the initial statement this morning?

30 THE PUBLIC: Well, yes, sir, but

1 we seem to have lost the track.

2 THE CHAIRMAN: Well, I thought
3 the purpose of this statement was precisely to answer
4 the questions you have raised. As for the emphasis in
5 the particular hearing, of course that depends on the
6 nature of the submissions that are made to us, and no one
7 should judge either the scope of our terms of reference
8 nor the focus of our own concern by the particular
9 emphasis of the submissions which happen to be given on
10 a given day or on the morning of a given day. But I
11 will repeat briefly the answers to the points you raised.
12 First of all we are required to inquire into the non-
13 medical use of drugs. We have defined non-medical use
14 as use which is not indicated or justified for generally
15 accepted medical reasons. But we recognize that medical
16 use may be use --- is used for generally accepted medical
17 reasons whether under medical supervision or not, not
18 necessarily under prescription, for example. And then
19 we are required to look at all the psychotropic and mood
20 modifying drugs and substances and we have drawn up
21 classifications to eight categories. I referred to five
22 of the most important this morning. And we consider
23 that alcohol is definitely included in our terms of
24 reference, and indeed so is nicotine, as I said in the
25 statement this morning. And we are looking at all of
26 these drugs, or at least at a fairly large number of the
27 most important in our inquiry. I don't know whether that
28 answers all your questions. Does it?

29 THE PUBLIC: Pretty much, sir.
30 Except that as a newsman I got the impression that the

1 older crowd in here were seeming to be zeroing in on
2 the kids, for whatever they are doing, while at the
3 same time my generation represented here in the room
4 seem to be hung up on quite a number of things that
5 weren't being mentioned.

6 THE CHAIRMAN: I don't know
7 how you can get that impression after some of the
8 testimony made by Mr. Wilkinson this morning about the
9 adult non-medical use of drugs.

10 THE PUBLIC: Well for instance
11 I notice nobody mentioned hypodermic needles. Many of
12 these things could be eliminated by the simple prescrip-
13 tion of that. There seems to have been, in my view
14 point, a number of personal value judgments bandied
15 about the room and a number of culture-bound value
16 judgments, none of which are supported by any kind of
17 data which was submitted.

18 THE CHAIRMAN: Now you are
19 making a submission to the Commission.

20 THE PUBLIC: Not really sir.

21 THE CHAIRMAN: I thought it
22 was a question-answer. I will sit back and receive
23 your submission.

24 THE PUBLIC: No sir, I just
25 merely wanted ---

26 THE CHAIRMAN: I see, you are
27 a combined director and witness.

28 Well, we have another scheduled
29 submission for the morning, and I must apologize to him.
30 It is Mr. W. G. Lewis of the Essex County Pharmacists'

1 Association. We thought we would be able to hear it
2 earlier. I wonder, Mr. Lewis, if it might be at all
3 convenient for you to return this afternoon as the
4 first submission, this afternoon?

5 MR. LEWIS: Yes, I can do that.

6 THE CHAIRMAN: That's very
7 kind of you. Thank you very much for waiting so long.

8 With that, then, I think I
9 will adjourn the hearing for --- until 2:30 P.M. this
10 afternoon, and thank you gentlemen, very much. Would
11 it be convenient for you to return this afternoon for
12 further discussion?

13 MR. WEEKS: Yes.

14 THE CHAIRMAN: At 2:30 P.M.

15 --- Upon adjourning at 12:45 P.M.

16
17
18 --- Upon resuming at 2:45 P.M.

19 THE CHAIRMAN: Mr. Weeks?

20 MR. WEEKS: Yes, sir.

21 THE CHAIRMAN: And gentlemen.

22 Are there further questions
23 or comments of Mr. Weeks?

24 Dean Campbell?

25 MR. CAMPBELL: In Section 18
26 of your brief, Mr. Weeks ---

27 MR. WEEKS: Eighteen?

28 MR. CAMPBELL: Yes. Where you
29 refer to a growing evidence of interest in heroin. I
30 wonder if you could expand on the nature of the evidence

1 you have for it.

2 MR. WEEKS: I think I will
3 have Mr. Freel answer that one.

4 MR. FREEL: I would say up
5 until approximately a year ago, we hadn't seen any
6 significant incidence of heroin among young people in
7 Windsor. There was the usual pattern of addiction, but
8 it was very small among the adults. The police did
9 not regard it as a serious problem in this area, and
10 approximately about a year ago now, fourteen months ago,
11 we had a bit of an epidemic of amphetamines --- meth-
12 amphetamine abuse and the people who were involved in
13 this by, I would say, July of last year, had discontinued
14 using amphetamines because of one particular incident
15 involving an individual who developed a pretty severe
16 case of amphetamine psychosis. And it was around this
17 time that a number of these people started to switch to
18 heroin, principally using it as an antidote to the
19 amphetamine problem. And since that time it has grown
20 to where we could probably estimate that maybe 35 to 40
21 people are regularly involved with heroin, ranging from
22 probably \$50.00 a day down.

23 MR. CAMPBELL: Is this mainly
24 in a population that had been using speed?

25 MR. FREEL: There has been
26 heroin experimentation by a number of individuals, quite
27 a number of individuals, and again you will see this
28 specifically in the brief Mr. Chandler will be presenting
29 in a brief as a social worker, will be giving information
30 on this particular question among the population we see

1 in our agency. But I would say that we have seen it go
2 beyond the original group that is involved with
3 amphetamines, and now involves others and we have heard
4 rumors to the effect that it is available in the schools,
5 like somebody can make a contact in order to get it.
6 We don't think it is being sold in the schools, but
7 there are people that have had an amphetamine --- or
8 have had a heroin problem who are periferal to the
9 school group, and some young people have also been
10 involved on this basis.

11 MR. CAMPBELL: Is it your
12 impression that there is any growing interest in
13 heroin?

14 MR. FREEL: I think it is
15 hard to say at this point. I would say that in terms
16 of a border area concerns of all of the drug developments
17 across the border, the movement of heroin down into
18 the high school level in the Detroit area is probably
19 of some considerable significance in this both in terms
20 of the amount of contact ^{by} the young people back and forth
21 across the border for various functions, and also the
22 fact of its availability. It has been very much higher
23 in Detroit than it would be elsewhere. They would
24 consider --- I think most people in Detroit would
25 consider heroin to be by far the worst drug problem that
26 they have. They have experienced a couple of cycles of
27 speed, and we have heard from a group of people over
28 there that work in the downtown area, that they are now
29 experiencng an increase in speed again, but that in the
30 main it has been pretty consistently growing in terms

1 of heroin and we are getting a bit of spillover from
2 that.

3 MR. CAMPBELL: Mr. Weeks, I
4 would like to raise two other questions that I suspect
5 your committee perhaps doesn't have a consensus on, but
6 I would like to hear the views of the members on them.
7 First of all, I would like to have your comments on the
8 interpretation of the drug phenomenon, as to what they
9 see, with reference as to what they see as the causes
10 of this phenomena and related to that I would appreciate
11 any comments that the members could make about differ-
12 ential motivation between the drugs or the tendency of
13 a particular population to use a particular drug.

14 MR. CHANDLER: I would like
15 to respond at least in part, to that request, Mr.
16 Campbell. In the area of motivation. I am not sure
17 that I want to comment on motivation for any particular
18 drug, but I will have some comments to make in a brief
19 from the School of Social Work. Since our study attempted
20 to look in a somewhat objective way at positive motivation
21 factors and while we were not able to carry out this
22 study as was originally designed, we did come up with
23 some indication of some trends and certainly some of
24 our certain impressions of people who are here, and we
25 have worked with the various groups, would be that probably
26 pretty consistently, that they ^{lacked} in the area of communica-
27 tion first of all, communication within the family, I
28 am not aware of any of the members of the group that I
29 work with who had what I would call healthy family
30 relationships. The feeling of helplessness with regard

1 to dealing with their own life situation in relation to
2 other kids, and in relation to people who affected their
3 lives in the school system, in the family and so on, I
4 perceived a feeling of helplessness. These would be the
5 things that would come out somewhat from our study and
6 also my own personal impressions having worked with some
7 of the kids. Now I don't think that is in direct
8 response to your question.

9 MR. CAMPBELL: Here you would
10 be referring to what type of individual? These would be
11 fairly committed drug users, heavy drug users?

12 MR. CHANDLER: Yes; yes.
13 Fairly heavy drug users. They tend to be somewhat ---
14 certainly somewhat better than average intelligence I
15 would say, quite introspective, tend towards creativity
16 without defining that very specifically. I would
17 describe them as for the most part creative kids. They
18 also tend to be quite articulate, verbally articulate
19 in terms of expressing ideas, feelings, and yet, on
20 the other hand having considerable difficulty in
21 relating to peers as well as adults. But at the same
22 time being aware that they have a difficulty in this
23 area and wanting to have deeper, closer relationships
24 with their peers.

25 In the area of the part of
26 your question related to sources, I would think perhaps
27 Mr. Freel would have more accurate information on that
28 than I would have.

29 MR. FREEL: Are you speaking
30 of sources of drugs?

1 MR. CAMPBELL: No, I was
2 talking --- thinking more of the sources of the drug
3 phenomena, and the particular sources of drugs.

4 MR. FREEL: Do you want to
5 add anything?

6 MR. CHANDLER: Well ---

7 MR. CAMPBELL: In other words,
8 what interpretation do you place on this thing?

9 MR. CHANDLER: Well, if I were
10 to identify any particular sources from which the drug
11 abuse problem emerges, I would place it in the area of a
12 feeling --- very basically a feeling of omnipotence on
13 the life of other people or life around them, with their
14 families, with school.

15 MR. CAMPBELL: Feeling of
16 omnipotence?

17 MR. CHANDLER: I am sorry,
18 impotence. Helplessness. I may have said omnipotence.
19 didn't mean that. Although that is certainly an effect
20 of drug use, but feelings of powerlessness, utter help-
21 lessness to deal with life around them, with a fair
22 degree of perseptivity of what is wrong with life around
23 them without too many concrete ideas or capacity.

24 MR. CAMPBELL: When you say
25 this are you thinking of life in general, or an inference
26 against the immediate environment or are you thinking in
27 terms of much more broader social problems or all of
28 these things?

29 MR. CHANDLER: I would say both.
30 I think, the broader social problems, but in addition to

1 this I think when it comes down to individual kids who
2 have a problem with the use of drugs, they too have some
3 very specific, very pressing, individual life problems.

4 MR. CAMPBELL: What is the
5 usefulness of drugs against this feeling of powerlessness,
6 escape?

7 MR. CHANDLER: Again I will use
8 this word "impotence", a feeling of impotence, a
9 feeling of not being able to deal with life's problems
10 as they come up, these feelings that many kids get from
11 the hallucinogenics. I think perhaps that while many of
12 them will feel that this is an illusory feeling, it is a
13 passing feeling, they will go back to it again and again
14 because of the lack of alternatives to have any power
15 themselves, with their own destinies.

16 DR. LEHMANN: Do they also get
17 it from the stimulants, such as speed?

18 MR. CHANDLER: Yes; yes.

19 MR. FYNN: I think another
20 aspect of this is through the reaction of the young person
21 to the rapidity of social and technological changes
22 that are going on all around. We have the
23
24 more urban centres, with urban centres, and now we
25 are being threatened with megaloposis, of people
26 being packed together tighter and tighter. There is the
27 whole area of leisure; people have more and more time,
28 and as a result of this an absence of any firm type of
29 structure which children of our generation could have been
30 fitted into. I am in a dilemma. I can afford --- or my

wife can afford a dishwashing machine, but if we go out and buy one, I don't know what chores will be left for my children to do.

Now let us go back, shall we say, fifteen or twenty or twenty-five years ago when the father of the family-- the farm family was an important factor of our economy, and merely to record what physical chores had to be done before the child went to school in fact, and what the child did after it came out of school, and the things that a mother did in a farm economy home, having and raising children was only one small aspect of the multitude of duties and tasks that she performed. All this has changed. We are not required to do these things any more, we don't even have to cook food. We can buy our food already cooked. And it is in these changes that have happened on us so fast and in a way they have never happened in history before, and it is in our attempt to adjust to this and to deal with this that the frustrations arise that cause some people to to lean towards drugs and I think this is very significant for us to know. But on the other hand, it does not cause other people to lean towards drugs. They are able to cope with these frustrations. Well, I don't know. I think it is interesting that the tranquilizer appeared on the scene at the time when the pressures from business, from industry, from our present life styles, the consequences of the automobile, and a thousand and one other things which are all pushed under the one heading of "the rat race". Could we have survived the "rat race" as a nation if we did not have tranquilizers? I don't know. As a

1 layman I ask this question. Has the tranquilizer saved
2 the North American society? I don't know. But it
3 certainly plays a great role. I remember when it was a
4 disgrace to be on tranquilizers. Not any more. People
5 show you their tranquilizers and tell you that they are
6 on tranquilizers and so on, and speculate whether it
7 is a - - whether it has helped them, you know,
8 whether it is, you know, the real thing.

9 I think we have a very complex
10 problem here which is not going to go away, which is
11 going to need all of the brain help and goodwill that
12 we can bring to bear on it.

13 MR. STEIN: Speaking on the
14 complexity of it, the reference you made at first about
15 the response to this change of life style, as you put
16 it, the response insofar as it may involve people in
17 the use of drugs, in your description of it you inferred
18 that there is a kind of attempt to escape from this
19 complexity, and yet we have heard from many people that,
20 at least in their estimation, they attempt to deal with
21 this complexity and to change from focusing on material
22 productivity and the development of material goods has
23 led them to experiment with drugs as a way of trying
24 to learn something about what their call inter-reality
25 In other words, the very same phenomena which you
26 described and which could perhaps be interpreted as
27 leading people to be frustrated and therefore wanting to
28 get relief from this frustration, there has also been
29 the interpretation that there has been a new opportunity
30 presented to us, a new preoccupation with human interaction.

1 And although some people claim more than others may, in
2 terms of what people can do with this preoccupation, there
3 is an attempt via drugs, they say, to examine and explore
4 new levels of human interaction. What is your response
5 or reaction to that point of interpretation?

6 MR. FYNN: Well this leads up
7 to my dilemma. Officially, I have an important role to
8 play as far as the courts are concerned, as far as drugs
9 are concerned. I have not taken one of these drugs. I
10 am not going to take one of these drugs --- marijuana,
11 speed, so on and so forth, yet I will be working with
12 people who have taken these drugs. Now how close can I
13 come to understanding --- I think this is what our
14 young friend was trying to get at a little earlier ---
15 if he is still here --- it is a real dilemma. Can a
16 person help a person when he has not been involved in
17 drugs, or can a non-user help one who has been involved
18 in drugs? Perhaps Mr. Freel has been more involved in
19 the drug aspect than I and would have something to say.

20 MR. FREEL: Perhaps to your
21 question, first, and then to go to yours, it would seem
22 that one of the ways we fall into this encounter approach
23 was because it seemed to present some rather interesting
24 alternatives, if we happened on it quite accidentally and
25 we found that it caught, and we understand now although
26 there isn't really very much literature in this whole
27 area, that others are using the same thing now on the
28 West coast, it is starting to develop in Toronto from
29 other areas of Canada and the United States, where people
30 are using some of these techniques, with people who have

1 been involved in the drug scene. In some cases, there is
2 a specific effort made, for example, in New York City,
3 to get people off drugs and in other cases it is not.
4 It is related to that. In some cases it is a declining
5 use. At that level, perhaps drugs have been included as
6 one of the number of ways that people are trying to fill
7 either a new need that they could not on that sociological
8 level before, due to preoccupation with survival and
9 security, and drugs is a method, is one of a number of
10 methods that people are exploring on domesticism and
11 sensitivity training and so forth. I think this is part
12 of it. I think, though, at the same time, we have the
13 kind of situation developing now where it is simply no
14 longer are we able to say this one thing or the other,
15 that we are starting to get --- I was thinking of types ---
16 speaking of types question. We are starting to get many
17 types of people, let us say kids, who are getting
18 involved with drugs. There are different kinds of things
19 happening there. I would say that very few of the people
20 that we see are involved and I am not just saying in the
21 clinical sense, I am saying even meeting on the street,
22 using drugs for philosophical reasons or exploring their
23 awareness, and they may attribute certain of these
24 things happening to them as a result of their drug use,
25 which may well be true. I think on the other hand,
26 though, that perhaps the nature of the drug scene is a
27 primary groups phenomena and essentially may have quite
28 a lot to do with this type of experience, where you are
29 together with people in essentially an illegal activity
30 and further where you are sharing an experience requiring

1 mutual support and just to get through the experience
2 with one another, that you may be intensifying
3 certain of these interrelationship and true personal
4 relationships. I think on the basis of causes, if you
5 want to attribute it to all of the drug use --- which
6 again I think is difficult --- but if you want to say
7 as far as youth is concerned, I think there are two
8 main reasons. One is boredom, and the other we would
9 say is immobility. Beyond that, we are starting to find
10 a great of kids are getting into it simply because
11 everybody else is doing it, and we find the group
12 pressure thing now is weighing far heavier as it spreads
13 out into the rest of the community in the so-called drug
14 community. As it is diffused, more group pressure seems
15 to play a greater part in what is going on. So now we
16 have far more of what you might say are straight kids
17 taking drugs and having problems earlier on than we
18 would be if they were existing in some sort of drug --
19 using subculture. I think there are a lot of kids now
20 who are getting stoned just for the sake of the feeling
21 involved. They want to change the way they feel. If
22 you take a group of kids who have nothing to do except
23 stand on the same street corner night after night after
24 night, that street corner starts looking the same after
25 a while, to the point of utter complete boredom. If
26 you can't think of anywhere else to go, or anything else
27 you want to do, then what better way than to change the
28 way the street corner looks, by changing the way you see
29 it? I think this is a very important fact.

30 THE CHAIRMAN: Professor

1 Bertrand?

2 PROF. BERTRAND: Would you mind
3 if we turned away from this kind of interpretation or
4 way of looking at the problem? I would like to ask you
5 what you meant exactly in Paragraph 37 of your brief
6 where you suggest, I think, that facilities --- where
7 you state that these are inadequate and I am wondering
8 if you suggest that like in Detroit we would ask the
9 law enforcement agencies to provide such ---

10 MR. FREEL: We were just using
11 the law enforcement agencies in this particular case as
12 an example. The Detroit system works in such a way that
13 you present a drug to your local precinct station and
14 you are given a number. There are no questions asked.
15 You 'phone up several days later and you are told whether
16 it is a dangerous drug. We do not feel this is the sort
17 of thing we are talking about here. Taken from the
18 law enforcement point of view, the time involving getting
19 any kind of reasonable service of federally operated
20 facilities is quite inadequate. The second part of the
21 problem, we would like to be able to get fast analysis
22 of --- this is from two points of view. First of all,
23 it is the major deterrent against use. The Foundation
24 Lab has criticized this for running a street quality
25 control, heavily by law enforcement people. Now we feel
26 here that very many people would be deterred from using
27 a lot of these underground drugs if they knew exactly
28 what was in the stuff.

29 PROF. BERTRAND: Yes, but my
30 question is related to what kind of agency would you turn

1 to as a sample?

2 MR. FREEL: I think the Health
3 Agency, such a thing as in most communities, of a hospital
4 having such a health unit. I think we have a unit here
5 specifically Provincial Government Laboratory,
6 this kind of thing or Federal Government Laboratory should
7 ^{be} established in each place.

8 MR. WEEKS: This matter was
9 brought to the attention of the committee by the law
10 enforcement people in the community, both the R.C.M.P.
11 and the local enforcement people. The reason why
12 they raised the question is as an explanation of why it
13 takes so long to prosecute a case of suspected drug
14 trafficking, and in order to get samples accepted in a
15 court, legally accepted in a court, it is necessary to
16 send them to Toronto, to a Lab in Toronto. I believe it
17 is, where there is a substantial backlog of other samples
18 from all over the place waiting to be processed, and it
19 often results in a time loss during which they may have
20 seized the supply of narcotics, suspected narcotics, and
21 the time it is established that they are indeed narcotics
22 so that this could stand up in court.

23 MR. FREEL: I think another
24 point here relates to this business that people who
25 are working in the area of drugs, having some kind of
26 protection against prosecution. Under the present law,
27 all of us are very much open. Anyone working in the
28 drug scene is open to prosecution and anyone who is
29 anything but intent to use the drugs, we actually
30 try to help people. This actually leads to some

1 communities --- not in this one --- we have cooperation
2 from the local police particularly --- but the police
3 do not help us one bit in treating that kind of thing
4 and I think it is my personal view that there is a really
5 serious problem here and in the law creating a very
6 large problem preventing us from getting at the people
7 who would come for help. They do not trust us, because
8 they think we will turn them in. They don't trust
9 virtually ^{helping} any agency. We have only just started now
10 to make a move in the City, the hospitals are saying
11 they won't 'phone the police on persons brought in on
12 hallucinogenic drug crisis, and there are some things
13 here which we feel really should be taken very
14 seriously.

15 DR. LEHMANN: That is
16 definite policy, the hospitals are not ---

17 MR. FREEL: There is one here
18 that has taken that position in terms of policy. I
19 cannot speak for the other three.

20 DR. LEHMANN: Why have not
21 the others?

22 MR. FREEL: I think it is a
23 question of pressure and it has been --- it is something
24 we are working at. It is a dilemma, it is sort of an
25 illegal activity and it is a moral responsibility to
26 report an illegal activity. Does a medical prac-
27 titioner in a hospital have a moral responsibility
28 that the police be called?

29 DR. LEHMANN: The physicians
30 see this from another sense.

1 MR. FREEL: I think this
2 whole area is very, very vague. I think this puts
3 people in the treatment field in a very difficult
4 position. On the other hand, it also puts the law
5 enforcement people in a very difficult position because
6 they haven't been getting the information. It is a
7 question of society making a decision and it is
8 which way are we going to go. Say that somebody
9 presents himself for treatment whether it is emergency
10 or long term, is to be treated in some way different
11 than another person who is similarly engaged in this
12 activity?

13 DR. LEHMANN: I am just
14 wondering whether your committee is trying to clarify
15 it somewhat, because we have been told in other cities
16 that perhaps it is not always the physician, it is
17 the administration, whatever that means, of the
18 hospital who said we can't take the responsibility,
19 whatever that means, not to denounce the person who is
20 coming in and has a drug problem. Now has your
21 committee considered having tried to straighten this
22 out? There seems to be a great deal of confusion which
23 is not a necessary confusion.

24 MR. FREEL: Not to this point.
25 Now we have the President of the one hospital who
26 makes the decision and this matter has been brought
27 before the committee --- to this point.

28 MR. WEEKS: I was just
29 going to confirm it, it has not been brought before
30 the committee to this point. It is a problem the

1 Drug Foundation have been dealing with themselves.

2 THE CHAIRMAN: Any further
3 questions?

4 If not, then I would like to
5 thank you Mr. Weeks.

6 MR. WEEKS: I would like to
7 thank you, Mr. Chairman, and Members of the Commission,
8 on behalf of our committee and I would also like to
9 wish you every success with your project and to
10 implement it as rapidly as possible as to the
11 recommendations you come to.

12 THE CHAIRMAN: I call now
13 on Mr. W. G. Lewis, Essex County Pharmacists' Association.

14 MR. LEWIS: Mr. Chairman,
15 Members of the Commission.

16 THE CHAIRMAN: Would you like
17 to introduce your colleague?

18 MR. LEWIS: Yes, this is Mr.
19 Gordon Cosgrave who is a pharmacist and also a member
20 of the Essex County Pharmacists' Association. He lives
21 in the City of Windsor and is a partner in the
22 Williams Pharmacy Limited.

23 Myself, I live in Harrow in
24 Essex County and I am employed as a pharmacist by
25 Darby Drug Store Limited.

26 We should like to present a
27 brief on behalf of the Essex County Pharmacists'
28 Association, and we would be glad to answer any questions
29 arising from that submission.

30 We would like to apologize for

1 not getting copies of our brief to the Commission ahead
2 of time, but we decided not to mail them due to the
3 uncertainty of the mail situation.

4 The Essex County Pharmacists'
5 Association is a voluntary association of pharmacists
6 in the County of Essex, Province of Ontario. Members of
7 the Essex County Pharmacists' Association come from the
8 retail, hospital, commercial and manufacturing pharmacy
9 practices. Founded in about 1924 and incorporated by
10 Charter in 1969, the E.C.P.A. is an active and viable
11 association in our area and in the Province of Ontario.

12 Pharmacy is a unique profession
13 in that it provides professional service plus tangible
14 goods at the same time. Pharmacists are remunerated
15 for their professional service only when they also provide
16 tangible goods in the form of a prescription or over the
17 counter products. Other professional services such as
18 advice, consultation with doctor, is freely given. In
19 spite of this fact our profession is demanding tighter
20 controls over drug use even though it could well affect
21 our incomes.

22 The pharmacists of Essex County
23 recognize that drug abuse is a pressing social problem
24 of our time and that some means of control based on
25 informed studies must be implemented. The E.C.P.A.
26 for the purpose of this submission, would like to deal
27 with those drug substances which are legally obtained
28 through pharmacies. In this submission the general
29 topic of drug abuse has been divided into two categories
30 namely, the over utilization of prescription drugs and

1 the misuse of so-called over-the-counter drug items.
2 This distinction is made because they are separate
3 manifestations of drug abuse involving different
4 problems and requiring different control approaches
5 by pharmacy and/or the Government. Also outlined in
6 this submission are some of the pharmacists' problems
7 in these areas, what the pharmacist is doing to diminish
8 this abuse, and hopefully what further steps must be
9 taken to alleviate the problem.

10 Over utilization of prescrip-
11 tion drugs Over utilization may be defined as the
12 taking of more drug or drugs than is necessary to
13 achieve a particular desired therapeutic effect. The
14 pharmacist, as a prime distributor of controlled drugs
15 has many problems trying to control the current "binge."
16 Among these problems are prescription insurance. The
17 rapid proliferation of third party prescription drug
18 plans has significantly increased the number of
19 prescriptions consumed by the public. This is especially
20 true of the Essex County Area where the majority of
21 people are covered. With insurance, prescriptions cost
22 next to nothing (25-50¢) and are therefore readily
23 available. Cost is no deterrent. Patients with insurance
24 will often present 3 to 4 prescriptions for the same
25 ailment where 1 or 2 would achieve the same results.
26 Third party plans encourage over-prescribing. For the
27 same reason, that being little or no cost, prescriptions
28 are often refilled when therapeutically unnecessary.
29 Experience in Saskatchewan has shown that a meaningful
30 utilization fee will inhibit overuse of medical services.

We therefore recommend that a minimum fee of \$1.00 per prescription, as a cash fee, should be built into all third party prescription plans. This move will undoubtedly decrease some of the misuse of drug insurance plans.

Prescription refills When the pharmacist obtains a 'phone okay for a prescription refill, he often has no definite knowledge that the doctor or the patient record card has been consulted. The nurse, receptionist or wife, rather than the doctor, often supply the okay. The Essex County Pharmacists' Association therefore recommends that pharmacists only accept 'phone refills as provided for by the Ontario Pharmacy Act, that is that prescription refills can only be authorized by the physician or his agent acting for him. This association also recommends that the agent's name should be noted on the prescription if the pharmacist is not sure that the doctor has been consulted. It may be necessary to abolish refill prescriptions except as indicated on the original written prescription. The pharmacist should not add to the harassment of the busy physician by 'phoning for refills, except in emergency situations.

Prescriptions for excessive quantities Excessive quantities for prescription encourages overuse, encourages theft by children from the home medicine chest and makes misuse and/or suicides and accidental poisoning easier. The Essex County Pharmacists' Association therefore recommends that as a general rule medication should be limited to

1 a one month's supply. The pharmacist should use his
2 professional discretion in many cases.

3 For various reasons, some of them
4 valid, such as poison control, there is a move by
5 physicians towards desiring the labelling of the drug
6 name on all prescriptions. It is obvious that a
7 labelled prescription for barbiturates, amphetamines,
8 tranquilizers, etc. will be that much easier to find
9 in the home medicine chest or steal during break-ins.
10 The E.C.P.A. therefore recommends that an objective
11 study of labelling be undertaken to look into all
12 aspects of prescription labelling before it becomes
13 general practice.

14 Sensationalization of drug
15 abuse

16 Publicity in all the media
17 sensational-wise is drug abuse and might turn the
18 curious into a drug abuser. The naming of specific
19 products rather than giving broad classifications of
20 drugs in newspaper and T.V. articles has made the
21 young person very knowledgeable about products which
22 are abused. This association is totally in favour of
23 a straightforward educational approach toward a drug
24 abuse problem. This seems to be the logical approach
25 to the eventual irradiation of this problem. It is
26 obvious that some common sense must be applied in this
27 approach.

28 Misuse of over-the-counter
29 drugs for self-medication.

30 Over-the-counter drugs (so

1 called O.T.C.'s) may be divided into two categories.
2 Patent and Proprietary medicines which can be sold in
3 any outlet to whom the manufacturer chooses to supply,
4 and those which can only be sold in pharmacies.

5 Patent and Proprietary
6 medicines. Many potent, abused, or overused medications
7 are readily available in non-pharmacy retail outlets such
8 as self-serve super-markets, variety stores and even
9 hardware stores. For example, the number one child
10 poisoner, common aspirin, is available almost anywhere.
11 Abused substances such as nail polish remover, glue
12 and spot removers are openly sold. These are commonly
13 abused substances. The E.C.P.A. recommend that all
14 patent and proprietary medicines be fully labelled and
15 that all outlets for these, and other commonly abused
16 items, control their sale at least to the degree that
17 it is now controlled in pharmacies. The pharmacist has
18 the advantage of special knowledge in drug matters.

19 Pharmacy O.T.C.'s; The modern
20 pharmacy with its accent on mass merchandising with
21 discount prices has many problems of O.T.C. control built
22 in. O.T.C.'s most often are on open display for self
23 serve or clerk service. The pharmacist is often too busy
24 filling prescriptions to make or control sale of O.T.C.'s
25 unless specifically asked advice by customers or clerks.
26 O.T.C. manufacturers interested in greater sales offer
27 quantity deals and encourage mass displays and promotions
28 of their products. Diabetic supplies, needles, disposable
29 syringes, medicine droppers and other equipment for
30 I.V. or I.M. drug abuse are often on open display and

1 freely sold. In an attempt to alleviate these problems
2 the E.C.P.A. has asked for voluntary action by all
3 pharmacists in the County of Essex. This association
4 has published a list of O.T.C. abused items and asked
5 that they be placed in a controlled area in or near the
6 dispensary, and that they should be sold only by or under
7 direct supervision of the pharmacist in charge. The
8 Essex County Pharmacists' Association has established
9 an "Abuse Alert" section to be included in their
10 monthly newsletter "The Dispenser". This will update
11 members on current problems. Our association urges all
12 pharmacists to become more concerned about drug abuse,
13 to become knowledgeable about it, to help control it
14 in their places of business and their community through
15 community involvements.

16 Our recommendations in regard
17 to O.T.C. products

18 Antihistamines - strong straight or combination anti-
19 histamine products should be in a controlled area.

20 Sale to be made by or under pharmacists' supervision.

21 Codein Preparations - pharmacists should be aware of
22 current and potential abuse of these items, he must
23 control sales more closely.

24 Diabetic supplies - needles, syringes and other diabetic
25 supplies should be placed in a controlled area for sale
26 by the pharmacist.

27 Patent and Proprietary Medicines - the E.C.P.A. urges
28 full labelling of drug content of all over-the-counter
29 medications. This will enable pharmacy to control
30 the sales.

1 Recommendations regarding
2 prescription drugs;
3 Amphetamines - the E.C.P.A. recommends that the Government
4 of Canada pass legislation to control the availability
5 and use of the drug Methamphetamine, known as "speed"
6 as well as the drugs Amphetamine, Benzphetamine, and
7 their salts, and anything that contains such substances,
8 so that their use and/or possession without the
9 authorization of a legally qualified medical practitioner
10 would be unlawful. It is further recommended that the
11 Food & Drug Directorate urge all Canadian physicians
12 to be more judicious in their use of Amphetamines, and
13 not to prescribe them for obesity control, in a
14 directive providing a list of suitable alternatives
15 and background information.

16 Psychotropic Drugs - large quantities of this class of
17 drugs are being misused, especially on third party
18 prescription insurance plans. The Essex County
19 Pharmacists' Association urges the awareness of
20 possible detrimental effects of long term overuse.

21 This association urges that
22 doctors' samples be placed in controlled area so as
23 to prevent their theft and use for forged prescriptions.

24 In summary, the Essex County
25 Pharmacists' Association recognizes the responsibility
26 of pharmacy to combat all aspects of the drug abuse
27 problem and has initiated a programme in Essex County.
28 This Association urges all pharmacists to voluntarily
29 begin tighter control of abused items in their business
30 places and their community. The E.C.P.A. also urges

1 action by all other local, provincial and national
2 pharmacy organizations to combat this problem.

3 The E.C.P.A. feels that some
4 changes in the legislation governing drugs are
5 necessary at a federal level, and that directives should
6 be issued by the Food and Drug Administration to ensure
7 uniform control measures in all Canadian Pharmacies.

8 Thank you, I would be glad
9 to answer any questions.

10 THE CHAIRMAN: Thank you, Mr.
11 Lewis.

12 MR. CAMPBELL: I am wondering
13 what specific controls on sale of patent medicines in
14 a business, ^{you suggest} /if in fact they were labelled. My impression
15 is that you have dangerous drugs like 222's on many
16 shelves of drug stores. There are virtually no
17 precautions taken and I have seen children walk into a
18 great many drug stores and buy 100 size bottles of 222's
19 without any questions being asked. If you are going
20 to bring them under any such control as you have here,
21 I am not frankly the least impressed.

22 MR. LEWIS: Legally, codeine
23 preparations such as 222's cannot be openly displayed
24 for self service. Now we have a Food and Drug Narcotic
25 Inspector who makes regular rounds and inspects this
26 very point. In Essex County, I feel fairly safe to
27 say that you won't find any 222's on open display in
28 any pharmacy. This includes your large super-market
29 type operations.

30 MR. CAMPBELL: What about

1 217's that don't contain codeine?

2 MR. LEWIS: 217's don't
3 contain codeine, and these are probably on most drug
4 store shelves alongside the aspirin.

5 MR. CAMPBELL: I am still
6 concerned about this level of control. Now you
7 mentioned yourself in your brief that aspirin is a
8 dangerous drug. Aspirin is almost never labelled as
9 a dangerous drug, but indications have shown that
10 aspirin very seldom points out its risks, the child
11 poisoning hazards, the dangerous risks, and surely
12 there must have been very, very few cases where a
13 person is cautioned when he buys a lot of 100 aspirins.

14 MR. LEWIS: There are new
15 labelling regulations on aspirin coming down from the
16 federal level right now. Aspirin is freely sold in
17 most outlets including drug stores. The control
18 that we are seeking and recommending and have voluntary
19 implemented in the County would be over more abused
20 items such as 222's, codeine cough preparations and
21 diabetic supplies. Our reference to patent and
22 proprietary medicines was simply because they are not
23 rated, we cannot exercise any control because we do
24 not know what is in them.

25 MR. CAMPBELL: The pharmacist
26 cannot refuse what he does not know the accounting of,
27 as a general practice in the profession?

28 MR. LEWIS: No. It would be
29 a very good idea.

30 MR. CAMPBELL: Yes. You are

1 the professional.

2 MR. LEWIS: Well, cigarettes
3 are most freely available in most the drug stores as
4 well which counter-indicates our whole law idea of
5 this brief. There have been a few stores, and we hope
6 there will be more that will exercise control over ---
7 they have thrown out cigarettes entirely and tightened up
8 control measures throughout the whole store.

9 DR. LEHMANN: About the
10 amphetamines, you said that you recommend the use and
11 possession without authorization of a legally qualified
12 medical practitioner would be unlawful. Is that not
13 the case already?

14 MR. LEWIS: To a degree. I
15 don't believe that possession in itself of large
16 quantities of amphetamines is presently illegal

17 DR. LEHMANN: Only the
18 distribution or the giving of the drug?

19 MR. LEWIS: Yes.

20 DR. LEHMANN: So you would
21 recommend some sort of a criminal charge for anyone
22 who possesses amphetamines without authorization?

23 MR. LEWIS: Yes.

24 DR. LEHMANN: And you also
25 recommend that Canadian physicians be more judicious,
26 but then you are quite specific and say they should be
27 by law prevented from prescribing them for obesity
28 control. Just for that particular condition, or just
29 be more judicious, or would you specify which condition
30 they could be prescribed for and not be prescribed for?

1 MR. LEWIS: Well, we couldn't
2 specify. Amphetamines are a drug of choice on very
3 few conditions, one being epilepsy. As far as pharmacy
4 is concerned, the use of amphetamines in obesity
5 control is very, very questionable but would not be
6 prepared to say that it is of no use whatsoever.

7 DR. LEHMANN: You did say it
8 here.

9 MR. LEWIS: Well, we have
10 asked that the Food and Drug Directorate provide a list
11 of suitable alternatives for amphetamine use in obesity
12 control, and we would hope it would cease.

13 DR. LEHMANN: Do you mean the
14 Food and Drug Directorate should limit the clinical
15 indications for the prescription of this drug, or that
16 they would make certain recommendations to the physician?

17 MR. LEWIS: We feel that they
18 should make certain recommendations.

19 MR. CAMPBELL: The definition
20 that has been given to non-medical drug use is such
21 that there could be drugs received when taken on
22 prescription that would be non-medical use in the sense
23 that it would be a contravention of generally accepted
24 standards of prescribing, knowledge of those levels and
25 so on. We also have been told very frequently of the
26 growing problem of the barbiturate industry, amphetamine
27 tendency, it has been the implication that this has been
28 a result in some cases of injudicious or quite improper
29 practice by the physician. As a professional person,
30 what responsibility has the pharmacist got to act and

1 | what action is available to them if he witnesses
2 | grossly injudicious or improper prescribing on the
3 | part of physicians whose prescriptions he receives?

4 | MR. LEWIS: We feel we have
5 | a professional moral right to protect the patient.
6 | However, whether this right goes to the extent of
7 | refusing to fill the prescription even though we feel
8 | that this is not that person's particular --- is not in
9 | his best interest, we don't know whether we have the
10 | right to legally or morally do this. We keep patients'
11 | record cards which is a fairly broad practice in
12 | pharmacy now. We know what drugs the person is taking
13 | We know what doctors he is getting them from and we
14 | know in what quantities he is taking them, and we feel
15 | we can make a professional judgment within the limits
16 | of our knowledge when he has taken too much. If we
17 | feel he is taking too much, our first step is to
18 | inform the physician.

19 | MR. CAMPBELL: Are you any
20 | more in the position to observe perhaps the wisdom of
21 | the physician? If you see a man who is consistently
22 | acting in the way you are describing, would it be part
23 | of your professional responsibility to advise the
24 | physician's licensing authorities? Conceivably the man
25 | would be a public hazard, that physician.

26 | MR. LEWIS: Conceivably, yes.
27 | But as yet there are no general guidelines along this
28 | line in most cases. It is individual professional
29 | discretion or judgment made on an individual basis.
30 | We probably have more problems with patients continuing

1 on refills of the prescriptions, than we do with
2 doctors over-prescribing or continuing, or continually
3 okaying prescriptions for patients.

4 THE CHAIRMAN: Gentleman at
5 the microphone?

6 THE PUBLIC: I am just
7 wondering what the opinion of the Essex County Pharmacy
8 Association is regarding the distribution of drugs not
9 through pharmacies but just through the regular channels,
10 through pushers and dealers. I was just wondering if
11 you have considered the aspect of the home-made drugs
12 and they are not through the manufacturers, but through
13 the so-called underground channels.

14 MR. LEWIS: We have tried to
15 limit ourselves to drugs which are normally obtained
16 through pharmacies. One of the reasons that we didn't
17 recommend a ^{straight} down on amphetamines was the
18 realization that any supply which is coming in legally
19 now could soon be made up by underground means.

20 THE PUBLIC: Do you have an
21 official position on that?

22 MR. LEWIS: No, we don't.

23 MR. STEIN: That raises an
24 interesting question. What is your view then, or
25 perhaps you have no official view, if not I am
26 interested in your personal view, on the situation
27 relating to hallucinogenic drugs which are banned at
28 the moment and do result in distribution through
29 illegal channels. Do you have any view about this
30 situation, whether controlled distribution would be an

1 improvement?

2 MR. LEWIS: I haven't an
3 official position. Personally, I would feel if halluci-
4 nogens are going to be used, if there was some way to
5 ensure at least the minimum purity or quality and
6 consistent strength through some body, it would be more
7 desirable than the questionable quality of underground
8 products which are now being used.

9 MR. CAMPBELL: We have been
10 constantly told that one of the major factors in the
11 role for drug use in this society, and I think it is
12 alluded to in your brief, is the factor that we have
13 come to believe ^{there} is a drug or a pill for virtually
14 anything, and if we have problems it will change this.
15 Now in a society there is not a small amount of
16 advertising of drugs. There is some on television, but
17 a great deal in the drug store itself. We heard a
18 brief yesterday from a group who apparently practice
19 pharmacy without open display shelves, where there is
20 simply a room, not a bit like the store in description,
21 there is a counter, you go to the counter and what you
22 want, you ask for, which would certainly seem to lessen
23 the pressure, and that same brief alluded to a study in
24 some part of Ontario on marketing of certain drugs, and
25 in 20 stores there was heavy / promotion. In twenty other stores there was an
26 increase of five shelves and in twenty other stores.
27 Where there was promotion there was 61% higher sales
28 of the tendency in society to look on drugs in this way,
29 do you think there is merit to the practice of these
30 other pharmacists simply not having display shelves or

1 simply having a counter over which drugs are sold?

2 MR. LEWIS: Personally, yes.

3 I am familiar with the operation that you are talking
4 of. From a personal standpoint, this comes as close to
5 the ideal practice of the profession of pharmacy as
6 anything you get ^{in Canada} / However, traditionally, the pharmacy
7 is the corner drug store where everything is available
8 from fly swatters to prescription drugs, and as yet
9 there is no significant move away from this type of
10 pharmacy practice.

11 THE CHAIRMAN: You have an
12 item here on Page 6, psychotropic drugs. Under that
13 list where you have amphetamines and next is psychotropic
14 drugs and it says "large quantities of this drug are
15 being misused. What drugs are you referring to?

16 MR. LEWIS: These are mood
17 elevating, mood changing drugs, tranquilizers, mood
18 elevators, anti depressants.

19 DR. LEHMANN: Well, this
20 point was previously discussed this morning, and I
21 would just like to get your opinion on it. What do
22 you mean by tranquilizers and anti depressants? Well,
23 more specifically, would you include for instance
24 phenothiazines under the tranquilizers, and
25 Elavil under the depressants, and if you do, do you
26 have any evidence that there is any extended non-medical
27 use of these drugs?

28 MR. LEWIS: We would tend
29 for our purposes to lump them all into one group and
30 we could put them under psychotropic drugs or tran-

1 | quilizers as a big lump. Except for excessive use on
2 | prescriptions, we don't feel that there is any move
3 | towards other non-medical use. Now excessive use on
4 | prescription would be getting refills month after month
5 | after month. Some --- we see patients all the time who
6 | are on this type of drug for six months, a year,
7 | eighteen months.

8 | DR. LEHMANN: For a schizo-
9 | phrenic for instance, or just for an epileptic, this
10 | would be called for for perhaps ten years in many cases,
11 | and the trouble the patients usually will not follow
12 | prescriptions. On the other hand, for a barbiturate,
13 | this would --- we would try to avoid this type of
14 | thing, and even if the doctor doesn't give the
15 | prescription, the patient might try to get the pres-
16 | criptions by other means. In other words, it is an
17 | entirely different way of dealing --- I mean one
18 | encourages non-drug use and the other part --- the
19 | other type of tranquilizer --- the trouble is it is
20 | just the opposite, that the patient doesn't want to
21 | take them and they should take them, and yet they are
22 | the ones which are the ones that are for over months
23 | and over years by hundreds of dosages that are being
24 | prescribed. So I cannot see the logic of lumping them
25 | all together simply because they are psychotropic drugs,
26 | not if you are interested in preventing drug abuse and
27 | non-medical use.

28 | MR. LEWIS: I misinterpreted
29 | your question. You are speaking of a control aspect ---
30 | from a controlled aspect.

1 DR. LEHMANN: Yes. Before
2 avoiding non-medical use --- abuse of the drug for
3 which there is practically no --- well, there is no
4 danger of phenothiasines, they are the ones that are
5 being prescribed over years and years, and nobody has
6 ever seen a problem that the patient would want to get
7 the prescription or get the drug without having to. The
8 trouble is usually that the patient won't take the drug
9 when he should. On the other hand, this is not true
10 for the minor tranquilizers, Librium, Valium,
11 the barbiturates, the problem is just the opposite.
12 Now to lump them together is a very confusing thing in
13 that the very large doses of course, the phenothiasins
14 and this brings us up to millions and millions of doses,
15 and it looks very frightening and yet it doesn't
16 represent the picture

17 THE CHAIRMAN: What is the
18 basis for your statement that large quantities of this
19 class of drugs are being misused? What is the basis
20 of that statement "being misused", what do you mean?
21 What is the basis?

22 MR. LEWIS: Well, we base
23 this partially on Mr. Wilkinson's brief and the Green
24 Shield utilization figures which were available to us.
25 We also based it on daily practice in the pharmacies
26 and seeing the quantities of these drugs which are
27 filled every day, it is quite amazing.

28 The ones that are being abused
29 are definitely amenable; type. This is where
30 they use minor tranquilizers.

1 THE CHAIRMAN: What is the
2 criterion of abuse? Is it large quantities, more
3 people using them, more people aware of them? They are
4 all being prescribed, are they not?

5 MR. LEWIS: They are all being
6 prescribed.

7 THE CHAIRMAN: What is the
8 criterion of abuse?

9 MR. LEWIS: We have housewives,
10 so-called housewives where the housewife may take them
11 and she may have a problem in the first month. Well,
12 that's fine, she may get a prescription refilled and it
13 will be an authorized refill, and she will continue to
14 get these month after month until she has a problem
15 with them.

16 THE CHAIRMAN: What problem?

17 MR. LEWIS: Well, she would
18 have some psychological dependency on them. The dosage
19 usually increases. The refills get closer together.

20 DR. LEHMANN: Perhaps you
21 are not really here to clarify the chronology, but
22 there is some confusion, and I would just like to point
23 that out. Tranquilizer is a bad term in the pharma-
24 logical medium. It lumps together two classes, the
25 major and minor tranquilizers. The minor tranquilizers
26 are the ones that will produce psychological dependency,
27 will produce tolerance and will also be quite frequently
28 abused, that is, people will try to get them without
29 prescription and when they shouldn't get them. The
30 major tranquilizers also being called just tranquilizers

1 are drugs that are taken reluctantly by patients, and
2 will not develop into physical or psychological
3 dependence, will not produce euphoria, will have rather
4 unpleasant side effects, and have practically 100%
5 medical use and 0% non-medical use, yet they will be
6 prescribed in very large doses over very long times and
7 therefore will swell the ranks of tranquilizers.

8 Now, since the minor tran-
9 quilizers produce abuse potential, or have abuse
10 potential and the major tranquilizers don't, but have
11 a very large volume involved, you get a spurious kind
12 of volume when you just lump them all together under
13 tranquilizers. I think this ought to be distinguished,
14 the major tranquilizers or neuroleptics should be
15 distinguished from the minor tranquilizers or extra
16 sedatives.

17 THE CHAIRMAN: Any other
18 questions or comments?

19 Would you use the microphone
20 please?

21 THE PUBLIC: Well, one of
22 the things that I was thinking of when he was talking
23 about the pharmacy is the idea, there is two kind of
24 drug problems. There is the underground culture of drug
25 use and then there is, like, what I would consider
26 straight drug use like the housewife using sleeping pills
27 and tranquilizers and, you know, alcohol included, and
28 there is the hallucinogens and heroin and, you know,
29 heavy methedrine and all that and, like, they are in
30 two different areas, because one is kind of a socially

1 acceptable one and one is completely non-acceptable and
2 you really can't deal with them in the same method.
3 Like, if somebody goes out and eats a jar of Gravol,
4 you know, like seasick tablets, it's not the same kind
5 of a legal problem as someone smoking marijuana, and
6 that's what I was just wondering, are you dealing with
7 it, I mean both terms, or do you think that any drug
8 abuse is just one common thing?

9 THE CHAIRMAN: Well, we have
10 got to look at both kinds of non-medical drug use. We
11 are not thinking in terms -- our terms of reference
12 don't contain the word abuse as a matter of fact. We
13 are asked to look at the non-medical use of all
14 psychotropic drugs and substances. What do you feel
15 are the significant distinctions in the two kinds of
16 use, apart from the different way they are treated in
17 the law in some places?

18 THE PUBLIC: Well, something
19 like a tranquilizer drug is -- like a person wants to
20 definitely change their mood, like, a hallucinogen like
21 LSD is not used for the same reason that someone would
22 use a tranquilizer, because LSD is like simulated
23 schizophrenia, it just tears your mind into little
24 shreds.

25 THE PUBLIC: How do you know?

26 THE PUBLIC: That is the idea
27 that has to be representative. A person doesn't go
28 take LSD for the same reason that they would sit down
29 and have a martini.

30 THE CHAIRMAN: Are you being

1 ironic?

2 THE PUBLIC: No, I am saying
3 this is the way it really -- like, the fact that a
4 tranquilizer, a person has a lot of tensions building
5 up and a lot of, you know, things around him and he
6 wants to find some way of alleviating it so he takes
7 a tranquilizer. So, like what he was talking about,
8 interdirecting this, a person is trying to find out
9 something, trying to have a religious or personal
10 experience, he takes LSD and he may or may not have it
11 but that is his reason for taking LSD. Not to calm
12 down or just to have fun sometimes, because in his own
13 sick way he might try to go out and have a religious
14 experience and wind up in a hospital, but he is trying
15 that kind of thing. But a person who does a tranquilizer
16 is merely trying to calm down and they don't have any
17 long range effect like, "Will I be a better person after
18 doing this drug?" They just say, "Well, things are
19 really bad and I would just like to calm down." The
20 same way when someone drinks a martini ---

21 PROF. BERTRAND: I get some
22 impression by the reactions in the audience, that not
23 everyone agrees with you.

24 THE PUBLIC: Oh, no.

25 DR. LEHMANN: What do they
26 not agree with?

27 THE PUBLIC: I don't know.
28 What don't you agree with?

29 DR. LEHMANN: What did you
30 say?

What was the answer?

THE PUBLIC: He is not one of us.

DR. LEHMANN: Oh, "He is not one of us."

THE PUBLIC: Well, I have said my piece.

THE CHAIRMAN: Any other comments?

Yes?

THE PUBLIC: We are talking about -- all morning we have been talking about abuse like you said, and it could be that there are uses for drugs, because Mr. Stein always is beginning to mention uses. And so we could probably look at a lot of uses, of drugs here, I suppose. You might not think they are good, but they are what is happening as Mr. Stein says, it might be some sort of a reaction, but it is what is happening, and people keep saying -- using it as an abuse but it is a use.

PROF. BERTRAND: You object not only to the word but to the conceptual thing of the misuse-abuse?

THE PUBLIC: Yes.

THE PUBLIC: While you were talking there, you were saying the Essex Pharmaceutical Association or whatever it is, they are saying you want to take on a humanitarian aspect and try to help people with the misuse of drugs. I was just wondering if you would be willing to give up a lot of the capitalistic

1 things that -- like, give up some of your profits in
2 order to help some of these people?

3 MR. LEWIS: In the introduc-
4 tion of our brief, we have stated, "In spite of this fact,
5 our profession is demanding tighter controls over drug
6 use, even though it could affect our incomes." We are
7 willing to ---

8 THE CHAIRMAN: I thought
9 your suggestion was to charge more, on Page 3.

10 MR. LEWIS: Is that a
11 recommendation?

12 THE CHAIRMAN: Your proposal
13 on Page 3 is you charge a fee of \$1.00 per prescription.

14 It is possible that Mr.
15 Wilkinson is concerned about the cost of the plans,
16 the premiums?

17 MR. LEWIS: No, this --
18 any increase in utilization fees should be reflected
19 in a decrease in premium rates. We are simply trying
20 to get this patient back to one or two prescriptions
21 which aren't going to give him the same effect. What
22 is happening is, he can come into the physician's office
23 and he will ask, "Do you have prescription insurance?"
24 If he does -- the patient -- the shoe may be on the
25 other foot. The patient may say, "I have prescription
26 insurance." Now, if he has the flu, he may get an
27 antibiotic and he could take an aspirin along with that
28 every four hours, but instead of that, he is getting a
29 prescription for an aspirin product at a much greater
30 cost. This utilization fee is simply to cut this down --

1 this type of utilization.

2 THE CHAIRMAN: Gentleman at
3 the microphone?

4 THE PUBLIC: Yes. There is --
5 I feel a bit of an inconsistency. In your brief, though
6 I didn't hear the whole thing, you alluded to, let's
7 say, the definition of a criminal, and really I get
8 the feeling from that by using the criminal law and so
9 on, what you are going to be doing is, let's say,
10 strengthening your materialistic sort of approach to
11 drugs and so on, and I am referring again to the
12 material again, and the part of the statement that
13 we said before that this isn't so much for the
14 humanitarian aspect or for purely tightening up
15 prescription control.

16 MR. LEWIS: We feel that the
17 pharmacist is a health professional. He knows what he
18 is doing and he has university training for specifically
19 what he is doing, and we feel that it is in the best
20 public interests to have potent medication, which all
21 drugs are, under his control.

22 THE CHAIRMAN: Are there any
23 other questions?

24 Yes?

25 THE PUBLIC: (Portion in
26 French).

27 THE CHAIRMAN: I should take
28 the liberty, because we don't have facilities of
29 simultaneous translation in this room; a point that
30 was made here in this room was that it is useless to

1 try to suppress one or more particular drugs because
2 people will turn to others, so that is a illusory
3 policy to try to suppress drugs. This is the contential
4 point.

5 It is very easy to replace.

6 PROF. BERTRAND: A drug by
7 a common substance.

8 DR. LEHMANN: The emphasis
9 should be on prevention and if that is not successful,
10 on treatment, but not try to hide things because it will
11 not prevent the use of the things in other words.
12 Hiding them won't prevent the use, and therefore,
13 treatment might be necessary, if the use leads to the
14 undesirable events.

15 THE PUBLIC: I was wondering
16 if this Commission could possibly reflect how the
17 people here, what their impressions would be of some
18 of the political aspects presently; right now. I imagine
19 there are in Parliament right now a few lobbies up such
20 as liquor companies and certain other groups who would
21 be very upset if dope was legalized and people would
22 turn to grass and get into that, and sales would drop
23 and moving on from that, what do you think would be the
24 political implications if dope was legalized? And, like,
25 everybody went into it -- marijuana, yes -- for a
26 start, marijuana.

27 THE CHAIRMAN: Well, we
28 can't express our views at this time on this forum,
29 our conclusions. There seems ---
30 I hope we are here to listen and not to express our

1 views on questions like that, but, of course, we will
2 express our views in our report.

3 THE PUBLIC: Could you give
4 us some kind of idea on what outside pressures there are?

5 THE CHAIRMAN: We have not
6 been aware of any outside pressures from industries,
7 nor have we been aware of any pressures by politicians.
8 As a matter of fact, we are not aware of any political
9 pressures.

10 THE PUBLIC: How about people?

11 THE CHAIRMAN: A lot of
12 pressure, yes -- if you want to call it pressure, a
13 lot of persuasion and eloquent persuasion from the
14 Canadian people.

15 MR. STEIN: But on this
16 question that you raised, it is perhaps interesting to
17 note that during the total course of our hearings, there
18 has been no representation to my recollection, from the
19 liquor industry at all to this Commission in any way.

20 THE PUBLIC: Okay, could you
21 kind of give me some idea of what happens when this
22 Commission finishes. Like, what is it going to prove?
23 Like, where are we after all this? We have a piece of
24 paper, do we get dope, or what have we got?

25 THE CHAIRMAN: What do you
26 think we should do?

27 THE PUBLIC: Legalize.

28 PROF. BERTRAND: Legalize
29 what?

30 THE PUBLIC: Legalize anything.

1 THE PUBLIC: If you want to
2 legalize it, you have got to get rid of the bad stuff.
3 There are maybe a few cases that bum out because of
4 that dope, but some are going to bum out anyway and if
5 they don't go to dope they go to alcohol and get so
6 drunk they kill somebody or something like that, so
7 something like that.

8 THE CHAIRMAN: You would be in
9 favour of no legal interference whatsoever with the
10 use of drugs, the trafficking with the use of drugs?

11 THE PUBLIC: Right, but a
12 lot of that is going to have to go with the change of
13 everything.

14 THE CHAIRMAN: That is
15 important, what are the other things?

16 THE PUBLIC: Will you be here,
17 will you give me 4:30, a half hour. Like, you have to
18 get into politics. All of this -- it is not, the
19 people are not on to what is the most economic thing.
20 You want a democracy and all that, it's nice to come out
21 to people and see what people think, but you can't go on
22 asking all the time and say that's nice, and put it
23 down on paper. If people want to do it, then why not?
24 Why have an up group and a down group? The people on
25 the down groups don't take it and like people were
26 saying barbiturates and all that, so why not have us
27 poor students and all that, have our own ---

28 THE CHAIRMAN: What, in effect --
29 are you saying that the state has no business concerning
30 itself in any way with the distribution and use of

1 psychotropic drugs?

2 THE PUBLIC: Distribution,
3 yes, cool.

4 THE CHAIRMAN: How should it
5 concern itself with distribution?

6 THE PUBLIC: Probably for
7 quality.

8 THE CHAIRMAN: It should
9 carry out the distribution?

10 THE PUBLIC: The Government
11 is for the people.

12 THE CHAIRMAN: We are speaking
13 now about all the drugs; we should carry out distri-
14 bution of all?

15 THE PUBLIC: We are speaking
16 of all of the drugs, we have Brewers' Retail and
17 liquor; we have grass; we have acid.

18 THE CHAIRMAN: Should the
19 Government distribute amphetamines?

20 THE PUBLIC: If the people
21 want them.

22 THE CHAIRMAN: The test is
23 whether people want them, and if they want them, the
24 Government should get into the business of distributing
25 them?

26 THE PUBLIC: Yes, if they
27 want the money, they can't just give it out, you know.
28 If they are stupid enough to pay for it, fine.

29 DR. LEHMANN: Would there be
30 price control? Should it be at a low price?

1 THE PUBLIC: If you are going
2 to stay in the capitalistic economy, you will have to.

3 THE CHAIRMAN: But, you are now
4 talking about the state distributing them.

5 THE PUBLIC: The Province?

6 THE CHAIRMAN: Well, let us
7 say, Government, one or the other. You are saying
8 about Government distributing them. You are saying
9 the Government should take it on themselves to
10 distribute this, state enterprise.

11 THE PUBLIC: All right now,
12 if you want to go into it deeper, like, why do people
13 want to take drugs? You are getting into that, but
14 you are not getting to the thing of why do people turn
15 to bad things like drugs. It is not the drugs that
16 are bad, it is the surroundings going on and it is the
17 whole sociological condition as to why people are
18 bumming out.

19 THE CHAIRMAN: That is what
20 we are trying to find out.

21 THE PUBLIC: But, you know,
22 you are asking pharmaceutical guys how much money they
23 are going to lose.

24 THE CHAIRMAN: No, no; no.
25 You have just heard some briefs today in Windsor. This
26 is the twenty-third sitting we have been through in
27 Canada, and we have heard many, many statements about
28 cause, and at some hearings we haven't seen a pharmacist
29 In the last two days we happen to have seen the pharma-
30 cists. I don't know why. I don't think it's pharmaceu-

1 tical conspiracy, but we have seen three of them, and
2 are very glad to because we are hearing things that we
3 did not have detailed analysis of, certain aspects. But
4 it happens in different communities. We tend to get
5 different emphasis, so there is no question about our
6 having heard a lot of talk. About cause, what is your
7 view about cause?

8 THE PUBLIC: Well, cause is
9 like, why I have to stand up here in from of a micro-
10 phone to make myself heard? Why do I have to go out and
11 scream at everybody? Why are people coming down on me?
12 I have just as much right to do with my life as I want.
13 Now, unfortunately, places like this get too big, I like
14 the world, and there is just too much bureaucracy
15 going on and people just can't be heard. Maybe that
16 is what Bob Chandler was saying, that they are escaping
17 in one direction, but they are not just backing away
18 from something, they are going into something else. We
19 just want a whole different culture and this is part
20 of it. And this, what I am standing in front of, is not
21 a part of it. It is kind of like a meeting with the
22 forces. And we are saying to you, like, as long as
23 you don't hassle us we won't hassle you. You never see
24 a hippie busting a cop. And the hippie hasn't done
25 anything to the cop. The hippie all the time is just
26 digging his people and wants a good trip.

27 PROF. BERTRAND: What is wrong
28 with the pharmacists?

29 THE PUBLIC: Well, that is
30 fine, it could be you are talking to people like this,

1 would it be worth it to legalize, or are people going
2 to lose too much money or gain too much money?

3 PROF. BERTRAND: Yes, but I
4 have heard for some months now, many people who have
5 said to us very straightforwardly that the great majority
6 of drug users at one point or another, exchange drugs
7 or sell drugs or pass them on to friends. So there
8 are many similarities between drug users and pharmacists.

9 THE PUBLIC: Listen, right
10 now in Toronto, like, it's so bad in Toronto, like
11 nobody's got jobs, like you are getting stuff second
12 hand and everybody is trying to make enough bread to
13 go back into school next year.

14 PROF. BERTRAND: If you want
15 to professionalize your ---

16 THE PUBLIC: No, I don't want
17 to make money, but I don't think anybody else should
18 make money too. So that's what it --- Peace.

19 THE CHAIRMAN: Well, thank
20 you, Mr. Lewis.

21 We call on Mr. Robert
22 Chandler, Assistant Professor of the University of
23 Windsor, School of Social Work.

24 MR. CHANDLER: Mr. Chairman?

25 THE CHAIRMAN: Mr. Chandler?

26 MR. CHANDLER: Members of
27 the Commission, first of all, if I may, I would like to
28 introduce to you some of my colleagues who have joined
29 me here today. I happen to be merely the person who
30 is reduced to writing some of these impressions. Some

1 of them are personal, some of them are the result of
2 a research project. I would like to first of all
3 introduce to you Mrs. Linda Popp who is one of our
4 graduate students. Unfortunately, the other two
5 students, Mr. and Mrs. Newton Smith who worked on
6 this project, are not able to be here because they
7 are out of town. The three of them are the ones who did
8 the hard work on the study and I was merely their consultant
9 while they were doing it. So I am glad that Mrs. Popp
10 is here today. On my left, Mr. Steve Pownall and with
11 him his wife, Mrs. Judy Pownall who is sitting here,
12 are two of the leaders of the small groups that I refer
13 to in the brief. Mr. Freel who you met this morning
14 in connection with the Civic Committee is still here
15 and he, of course, is responsible for the encounter
16 programme at the Addiction Research Foundation and he
17 is supporting, and he is here to be in support of
18 some of the comments that I make. Also Professor
19 Bernie Kroeker of the University of Social Work served
20 as a member of the Research Committee. This submission
21 consists of a summary of a study of possible motivational
22 factors for the non-medical use of drugs among teenagers
23 together with some of my own impressions, based on a
24 year's work with one of the treatment groups whose
25 members were subjects for this final study.

26 The project was entitled
27 "A Study of the Possible Motivational Factors Behind the
28 Non-Medical Use of Drugs" and unpublished copies of the
29 thesis will be deposited in the library of the University
30 of Windsor.

The study was undertaken because researchers along with others had noted that there was a dearth of objective research findings in the area of motivational factors for the use of drugs among teenagers. Much has been said and written about the reasons for using drugs, but much of it is in the form of opinions. However well informed these opinions might be, very few attempts have been made to investigate this area in a controlled way. The researchers felt that it was important to obtain data of this nature as a basis for the development of sound community preventive, educational and treatment programmes to deal with the problem of teenage drug use. It seemed timely and appropriate to conduct a project of this nature in Windsor, since this community had already confronted the problem realistically and effectively through its Civic Committee on Drugs, through its two Boards of Education, and through its local office of the Addiction Research Foundation, as well as a number of community groups. Such findings, we thought, would be of specific use to these organizations in their efforts.

With this in mind, the researchers approached the Windsor Board of Education with a proposal to investigate a random sample of high school students through the use of a scale questionnaire with the anonymity of the respondents scrupulously protected. The research instrument was designed so that it would be possible to obtain a subject sample of students who had used drugs once a

1 twice a month, once or twice a week, or once or twice
2 a day, and a control sample who had never used drugs
3 non-medically at all. The response of those who
4 indicated in the questionnaire that they seldom used
5 drugs, that is once or twice a year, would be deemed
6 to be casual experimenters who could not be considered
7 either users or non-users and were, therefore, to be
8 discarded for the purposes of this study.

9 For reasons unrelated to the
10 purposes or design of the study, the Board of Education
11 did not see its way clear to permit the study to be
12 conducted at this time and the design was therefore of
13 necessity changed to permit the study of the members
14 of the group treatment programme at the Addiction
15 Research Foundation. They gave its approval to the
16 study and assisted extensively in facilitating
17 collection of data and providing technical and
18 clerical services.

19 The study as finally conducted
20 and I wish to emphasize this, limits the value of the
21 findings since a control group was lacking and the
22 study group was a special one in that it consisted of
23 users participating voluntarily in a treatment
24 programme. As such, they could not be representative
25 of a teenage population and probably not even completely
26 representative even of the teenage drug scene because
27 of their participation in treatment. However, the
28 findings are interesting because of the special nature
29 of the sample and point to some directions for preven-
30 tive and treatment programmes.

There were 67 respondents in all, 48 of whom were male and 19 were female. They ranged from between an age of just under 17 to just under 18 with the girls being about one year younger than the boys. They came from families with between two and three siblings and 76% came from families with an income of between \$5,000 and \$15,000 a year. They, therefore, conform in family size and income level to the typical middle-class family.

66% of the females and 76% of the males lived at home with both parents, while the remainder lived with one parent or with some combination of step-parents.

The females tended to use drugs more extensively than the males, with 37% reporting usage once a day as compared to 3% of the males. However, 94% of the males reported usage at least once a month as compared to 63% of the females.

Marijuana was the most widely used drug, with 98% of the males and all of the females reporting use, followed by LSD (98% of males and 100% of females) and codeine cough syrup with 86% of the boys and 63% of the females reporting use. 71% of the males and 73% of the females reported use of amphetamines; and 77% of the boys and 68% of the girls used barbiturates and tranquilizers; 46% of males and 21% of females reported heroin use. It is interesting to note here that all of the girls had used both marijuana and LSD and the percentage of

1 amphetamine use was slightly higher and that of
2 barbiturate and tranquilizer use was slightly lower
3 among girls than among boys.

4 There is a noticeable difference
5 between males and females in reported reasons for use.
6 The majority of girls reported reasons related to
7 improving relationships with peers, while the
8 majority of males reported reasons related to escape
9 or "just to get stoned."

10 The study proceeded from
11 hypotheses related to effectiveness of communication
12 in the home, degree of dependency upon peers, and
13 effectiveness of participation in school. Twenty-one
14 questions were directed at obtaining data on each of
15 these areas and these were mixed together in the
16 scale.

17 Males seemes to experience
18 somewhat better communication in the home than did
19 females, although a large majority of both experienced
20 only fair communication. Few had good or very good
21 or excellent communication as measured by the
22 inventory of questions used for this area. For this
23 particular area of study, we used a communication
24 inventory which has been standardized at the University
25 of Louisiana by Professor Millard Bienvenu.

26 There was a small number of
27 group members who reported no use of drugs, and while
28 this could not by any means be considered a control
29 group because of its size, the fact that they were in
30 close relationship to users in a treatment setting, it

1 is interesting to note that there was evidence to
2 indicate that this group experienced much better
3 communication in the home than did the users.

4 MR. STEIN: May I ask a
5 question on this? In relation to the scale, I don't
6 recall reading in the report the criteria that are
7 used. Is it in there, or did I miss it when I read
8 through it? Like in other words, the scale that you
9 are referring to for measuring communication, criteria
10 in other words for this communication, is there a
11 reference to that in some way that one can learn what
12 the criteria are?

13 MR. CHANDLER: Yes, I would
14 like to turn that over to Mrs. Popp. The scale used
15 there was a Parent-Adolescent Communication Inventory
16 by Professor Bienvenu at the University of Louisiana.
17 Maybe Mrs. Popp could respond to that.

18 MR. STEIN: What I am interested
19 in is knowing something about what that scale --- what
20 are the criteria of the scale for communication? You
21 make reference to positive and negative communication.

22 DR. LEHMANN: Is the scale in
23 the appendix?

24 MR. CHANDLER: No, the scale
25 could be provided to the Commission. That is an oversight.
26 It is available and we would be happy to send it to you.
27 Perhaps you could exemplify some of the typical questions.

28 MRS. POPP: It is a five-point
29 scale. Like each question has a five point scale, you
30 know, do you talk problems over with your parents, and

1 then there is always, usually, sometimes, seldom or
2 never, and it has been standardized by this man at the
3 University of Louisiana. But I don't know what you
4 mean by criteria.

5 MR. STEIN: That is the sort
6 of thing that I mean. For example, taking that question,
7 would therefore the scale be interpreted as meaning
8 there is positive communication if there is a high
9 frequency of discussion?

10 PROF. BERTRAND: What is this
11 communication you are speaking of, especially on Page 14
12 for instance. Communication is transmitting of positive
13 feelings.

14 MR. POPP: What we do is we
15 take a middle point, sometime, always, usually. Sometimes
16 is considered average, and this is how he has done this
17 scale and we used his scale. So "usually" is considered
18 average communication.

19 MR. STEIN: I think the point
20 we are trying to make is, supposing the communication
21 consisted of expressing negative feelings?

22 PROF. BERTRAND: It is
23 communication still.

24 MR. STEIN: Is that not
25 communication?

26 PROF. BERTRAND: But you define
27 it as positive --- as transmitting positive feelings.

28 MRS. POPP: It is a five
29 point scale.

30 PROF. BERTRAND: I am reading

1 from your text.

2 MR. CHANDLER: Communication
3 is transmission of positive feelings, is the way that
4 it has been defined.

5 MRS. POPP: So in other words,
6 poor communications is transmitting negative feelings.

7 MR. CHANDLER: One question
8 in this scale which the research group selected for
9 particular examination were the responses to a question
10 of having to do with the discussion on matters of sex
11 openly with parents.

12 PROF. BERTRAND: Yes, I know.
13 This was one criterion of good communication with parents.
14 I would like to question you on that also.

15 MR. CHANDLER: Well, certainly
16 that would be open to question. It was felt that at
17 this point it would be an indicator as far as measuring
18 instruments that we have at the present time. It was
19 an indicator of the qualification between parent and
20 child.

21 PROF. BERTRAND: Would not drug
22 be the best indicator since this was really the object
23 of the study? You know, why do you speak of sex as being
24 the criterion of open communication with parents?

25 MRS. POPP: That is only one
26 of the questions.

27 PROF. BERTRAND: Yes, but it
28 is the top one. I read it. The top one.

29 MR. CHANDLER: In this
30 particular part of the scale, we wish to use the

1 communication inventory which was designed for
2 adolescents in general and not for drug users specifi-
3 cally. I think also, the population of drugs users, we
4 wanted to move beyond the symptom of drug use, the
5 symptom of drug abuse in the study as well.

6 THE CHAIRMAN: Would you
7 like to continue?

8 MR. CHANDLER: Yes.

9 In relation to dependency
10 upon peers, there is some evidence to support that
11 dependency upon peers increases directly
12 with frequency of drug use.

13 In relation to school, the
14 majority of both male and female users tend not to
15 be involved in either athletic or non-athletic extra-
16 curricular activities. There is an inverse ratio
17 between frequency of drug use and degree of school
18 involvement among the group studied.

19 The majority of school marks
20 reported ranged between 60 and 70% with little change
21 over a three year period. Now these were not taken
22 from school records but reporting on an anonymous
23 basis of the respondents to the questionnaire. I
24 personally found this interesting, that by and large
25 these members were achieving in school with at least
26 average results.

27 School attitudes tended to
28 be more positive among less frequent drug users,
29 although the majority had only "average", that is
30 neither positive nor negative attitudes as measured by

1 the inventory of questions used in this area.

2 Now, because of the limited
3 nature of the group used in this study, the findings
4 of course, are of limited value, and the researchers
5 have emphasized the need for more extensive research
6 around possible motivational factors, particularly
7 in the area of parent-child communication, and I
8 would stress the word "possible" here because we are
9 not suggesting that there is necessarily a cause--
10 effect relationship between material we were looking
11 at, but perhaps these were areas that should be looked
12 at in more detail and in a research way.

13 Now I would support this
14 recommendation based on both the findings of the
15 study as well as on my own impression in working with
16 one group of the kids who were involved in the study ---
17 subjects of the study. This particular group that I
18 worked with composed of boys and girls at the younger
19 end of the age range between 15 and 17, all of whom
20 were in school with two having dropped out and one
21 having been permanently suspended during the year of
22 the operation of the group, suspended "unofficially"
23 because of the length of his hair, did not conform to
24 school regulations. Incidentally, this particular boy
25 was performing, at least by the measurement of school
26 marks, at an average of 80%, while using drugs heavily,
27 but he was asked to leave school at this point.

28 None of the members of this
29 group had what could be called a healthy family life
30 with open communication amongs its members, and none

1 had positive attitudes towards school. One member
2 took amphetamines during mid-day at school "in order
3 to stay awake." to use his words.

4 The group members tended to
5 be introspective and reflective, with a need for close
6 peer relationships. This need for close relationships
7 was perhaps strengthened by the absence of such relation-
8 ships in the family, and this, together with a feeling
9 of powerlessness to change their existing family or
10 school situation seemed to motivate these young people
11 to use drugs. As one member said, "I know my dope-
12 taking is a cop-out, but I can't find any other way
13 right now." And as the group meetings progressed,
14 interaction focussed less upon drugs and more upon
15 awareness of self and relationships with others. People
16 have asked us if we sit around week after week after
17 week discussing peoples' drug use and very quickly with
18 all of these groups, and I think it has been the
19 experience of all of us involved in the groups, that
20 they --- the interaction that takes place moves very
21 quickly beyond the topic of drugs to more fundamental
22 areas. A number of the members of this group and
23 others have described the group experience at times
24 as like being "naturally stoned", which seems to
25 suggest that this mode of intervention with users is
26 effective in providing an alternative to drug use.
27 The ultimate test of its effectiveness, however, must
28 be to the extent to which there can be continued carry-
29 over of functioning learned within the group into
30 everyday life experience.

From the evidence obtained from the study, and from my own experience, I would emphasize the need for intervention with the family groups as well as peer-group intervention. The method of treatment in which the worker sees the family as a whole as the unit of treatment and where the problem is seen as a total family problem requiring involvement and commitment of all the family members to its solution seems to be the most promising approach, at least from our limited experience here. This, together with groups of users and combined groups of users and their parents where the emphasis can be working through barriers to communication, along of course, with ancillary medical services, would provide a comprehensive approach to the treatment of the problem of "soft" drugs, or those where dependency is psychological in nature. As in all treatment of course, the goal must go beyond the symptoms of drug use to the underlying problems of self-concept and inter-personal relationships.

However, programmes of prevention must be developed (and help us define) if we are to resolve the problem of teenage drug abuse in any lasting way. Here too, we must move beyond a focus upon drugs, although adequate educational programmes which provide information about drugs, their effects, and hazards involved must continue to be an important part of any community preventive programme. It is my opinion that we must give attention to the quality of community life, the quality of relationships

1 among all of the people in the community, young and
2 old alike. The pace and style of modern life mitigates
3 against the development of interpersonal relationships
4 of an open, honest and humanly caring quality. Even
5 our social and recreational activities are programmed
6 with a fixed agenda of such things as basketball, chess,
7 cards, guest speakers, etc. While I am not suggesting
8 that these activities do not have considerable merit,
9 little or no time is left for just getting together
10 and being with each other in a real attempt to examine
11 our relationships in day-to-day life and act upon
12 improving their quality. Opportunities must be provided
13 for young and old to do this together. An example of
14 one of the community's attempts to do this is an
15 example of one of the parent's groups which has planned
16 a programme of three evenings within one week. The
17 first evening, 150 parents will get together in ten
18 informal groups to talk about themselves and matters
19 concerning themselves. The second evening, 150 young
20 people will do the same. The third evening, even
21 smaller groups made up of three or four of the parents
22 and three or four of the young people will come together
23 in a similar way. The groups will attempt to get
24 beyond talking about problems of communication to
25 actually working on them, and hopefully something in
26 the nature of a continuing programme will result. As
27 least one church is already doing this with a group
28 of adults and teenagers meeting together weekly in a
29 basement recreation room with no other programme than
30 themselves. It is interesting to note here that in our

1 initial ideas to plan this, we had to plan a programme
2 that did not have an agenda and was not scheduled.
3 Everyone seemed to be asking what are we going to do
4 in three hours of time, with a great deal of fear about
5 just putting people together, and letting whatever
6 they wanted to do, happen. If we can provide opportunities
7 such as these which seek to humanize the quality of
8 community life and provide for real participation and
9 discussion - involving young and old alike, in
10 addition to structured social and recreational activities
11 all too often planned by the old because they know
12 what's best for the young, we will go a long way
13 towards eliminating the need for chemical dependency,
14 not only among teenagers, but among adults too.

15 I would summarize the
16 recommendations rising out of this submission in three
17 points; firstly, the need for extensive research into
18 possible motivational factors for the non-medical use
19 of drugs and especially a new examination of the
20 relationship between the quality of family communication
21 and drug abuse. Secondly, treatment programmes that
22 involve the entire family, through family therapy where
23 the family as a whole is the unit of treatment, and
24 group therapy where parents and teenage users meet
25 together. And finally, preventive community programmes
26 that give opportunity for adults and young people to come
27 together in an unstructured way to explore themselves in
28 relation to each other and take action together to
29 improve the quality of family and community life.

30 Mr. Chairman, I would hope

1 that for questions, that those who are with me would
2 involve themselves at any point they see fit.

3 THE CHAIRMAN: Thank you
4 very much, Mr. Chandler. This is a very small sample
5 of persons who engaged in a fairly extensive programme.

6 MR. CHANDLER: Yes, quite a
7 small sample.

8 THE CHAIRMAN: The percentage
9 for example of LSD is unusually ---

10 MR. CHANDLER: Unusually high.

11 THE CHAIRMAN: I guess you
12 are not in the position to generalize from this study
13 as to how you think the level of LSD use compares
14 generally with the level of cannabis use?

15 MR. CHANDLER: From the study
16 I would be very hesitant to generalize because it was
17 a very special sample, and in many ways, a biased
18 sample.

19 DR. LEHMANN: How big was
20 the sample?

21 MR. CHANDLER: Sixty-three
22 respondents.

23 DR. LEHMANN: About two-thirds
24 male?

25 MR. CHANDLER: About two-
26 thirds male, yes. Certainly from this study I would
27 not ---

28 THE CHAIRMAN: How did you
29 select the degree of drug use that you felt was
30 appropriate for this sample? For example, how did

1 you select these people out from a large body of
2 marijuana or cannabis users? What was your criterion
3 for selecting them?

4 MR. CHANDLER: These people were
5 already members of our encounter group which comprise
6 the programme of the Addiction Research Foundation and
7 a questionnaire was administered to all of the members
8 of those twelve group.

9 DR. LEHMANN: Was it a research or
10 therapeutic programme?

11 MR. CHANDLER: No, the purpose of
12 the programme was therapeutic.

13 DR. LEHMANN: Therapeutic?

14 THE CHAIRMAN: That is why they were
15 in groups, they were there for treatment?

16 MR. CHANDLER: They were there for
17 treatment not for research purposes, primarily.

18 DR. LEHMANN: So they wanted treat-
19 ment to start with?

20 MR. CHANDLER: Yes. This is why I
21 emphasize this is not a representative sample even of
22 drug users because they wanted treatment and then
23 voluntarily came to the group.

24 THE CHAIRMAN: What were they seeking
25 treatment for? For example, there is a high degree of
26 multiple drug use in these figures, practically 100%
27 cannabis, 100% LSD, over 70% amphetamines, 70% barbiturates
28 and tranquilizers and then the very high usage of heroin.
29 Now what were they being treated for, this multiple drug
30 dependency generally or---

1 MR. CHANDLER: Mr. Freel will
2 respond to that.

3 MR. FREEL: I think a word of
4 treatment involved:
5 explanation as to the/first of all the programme is
6 voluntary and in the second case it is, I would say,
7 probably 75% self recruited or recruited by friends,
8 and in the third case ^{are} probably better than 60% /there
9 without their parents' knowledge of their participation
10 in this. The fourth point, we would have to clarify
11 very extensively exactly what we mean by treatment, in
12 the sense that I don't think either they or we were looking
13 at it specifically as an attempt to reduce their
14 drug involvement as a main goal. They are there because
15 they feel this is some place they can come and talk to
16 people and become involved with people in a kind of a
17 way where they can't do this anywhere else. A number
18 of them will admit that they have drug problems and want
19 to straighten this out. A number of others, however, do
20 not admit they have drug problems and there is no
21 attempt made on the part of any of the people, either
22 members of the groups or the people running groups, to
23 convince them that they do have. If it turns out in
24 the course of the interaction and development of the
25 relationship with the people, we find that an individual
26 is starting to recognize that his use of drugs is causing
27 him a problem, then we will help him work that through.
28 But it is a very flexible open-ended sort of thing with
29 a fairly high turnover. This is the only way we have
30 really found that we are able to reach these people even
to the point of communication, and I think it started out

1 originally as an attempt on our part mainly to communicate.

2 THE CHAIRMAN: You call these
3 encounter groups? Do they function similarly to the
4 drop-in centres?

5 MR. FREEL: No, we have kind
6 of combined several different approaches, sensitivity
7 training, some of the work that has been done in
8 Echelon and similar places like that among Drugs
9 Anonymous, and we are now starting to recognize one of
10 the most important functions of these groups seems to
11 be the creation of this natural high, and I don't know
12 if you are familiar with Dr. Malcolm's paper on the
13 implications of drug abuse "Altered States of
14 Consciousness" and we are starting to wonder if in this
15 whole area there might be some very significant connec-
16 tion, at least in the terms of the kind of commitment
17 or involvement we seem to get over, for some people,
18 as much as a year and a half, and during that time, a
19 substantial reduction in drug use voluntarily.

20 THE CHAIRMAN: Would it be
21 possible for you to give us a description of what you
22 are doing? We have made a comprehensive study of
23 integrated services in new attempts to work constructive-
24 ly in this field, but you are only actually examining
25 techniques of therapy --- well, we can use the word
26 treatment.

27 MR. FREEL: We don't like to
28 use the word treatment.

29 THE CHAIRMAN: I know, but
30 what is the best word, then?

1 DR. LEHMANN: Intervention?

2 MR. FREEL: Well, intervention
3 would be the best word.

4 THE CHAIRMAN: Would you be
5 able to give us a description of your work, at some
6 time --- I mean a written --- send it to us?

7 MR. FREEL: Yes, we definitely
8 can.

9 THE CHAIRMAN: Yes, that would
10 be very interesting.

11 MR. FREEL: I was going to
12 say verbally, right off the top ---

13 THE CHAIRMAN: No.

14 MR. FREEL: Yes, very
15 definitely.

16 DR. LEHMANN: May I ask one
17 question in response to what you just said? You said
18 a natural high is something similar to what is being
19 created as the drug use goes down. Now do these
20 people then sort of develop something like a dependency
21 on the group?

22 MR. FREEL: This has been a
23 problem and it is one of the areas where I think Bob
24 touches on in his presentation, that we are beginning
25 to find where we have involved the family in a work
26 reality way, we are starting to see some kind of
27 transference of this experience outside of the group.
28 One of the problems was, ^{as}seems to take place with all
29 this kind of group technique, whether it takes place
30 in a therapeutic context or not, is this dependency

1 developing on the group.

2 MR. CHANDLER: Yes, I think
3 that certainly what we have discovered, we started
4 out --- I think Peter referred to us having fallen
5 into this when we first started and that was about it.
6 We found something that seemed to have meaning to kids,
7 and what was a drop-in centre programme to start with
8 of some 100 kids in the basement of the Addiction
9 Research Foundation every Wednesday night, we discovered
10 that when we began, because some of us were more
11 interested in working with small groups, that we would
12 just get together a group of kids and see what would
13 happen and some of the kids were saying "Wow, this
14 is like being naturally stoned". So we thought, well
15 let's look at this, maybe we should be trying this,
16 this informal approach of treatment, if you like.
17 However, we very soon found that while we could bring
18 about some change certainly in the area of dependency
19 upon drugs and abuse of drugs, although certainly not
20 abolishing use of drugs, unless --- well change took
21 place in the group, or the individual at that time,
22 unless there was some intervention in a significant
23 area of life experience in the members, that is in the
24 family itself, there was no lasting effect.

25 THE CHAIRMAN: Gentleman at
26 the microphone?

27 THE PUBLIC: I think this
28 brief is difficult on a lot of things that is happening
29 in discussion of drugs mainly because these people are
30 trying to do an honest job, but they are dealing with

1 a very unique set of drug users. They mostly have
2 emotional problems either stemming from drug use or
3 problems that they had before they ran into drugs.
4 There is no talk and no voice from the average kid
5 using drugs. A kid who has his part time job and uses
6 drugs on the side, you don't hear anything about these
7 people. I think the Commission fails in their duty
8 because of this, that is, on the face of the duty, in
9 the case of case histories of abnormal drug use, kids
10 who have had trips or were introduced to heroin, you
11 would not be dealing with the average kids.

12 THE PUBLIC: (portion inaudible)

13 THE PUBLIC: Like this brief
14 is ridiculous. Like I was saying it was an abnormal
15 group and I don't see how you can form any opinions
16 dealing with this, because it is not a controlled group
17 at all. It would be like studying people who drink
18 alcohol by studying alcoholics.

19 MR. CHANDLER: That is
20 precisely the point. We were prevented from carrying
21 out the original study. We would have done that.
22 would have We /looked at a "normal group" of school attending teen-
23 agers and hopefully at some time in the future this
24 will be possible. As a necessity, we had to actually
25 go down to Plan C of our research project and do
26 something which, well, was not by any means ideal. It
27 was realistic, and let's face it, we had three students
28 who wanted to graduate too.

29 DR. LEHMANN: And also in
30 studying a group of alcoholics, one does learn something

1 about the ones potential of alcohol.

2 THE PUBLIC: But also, you
3 know, I think you are planning legislation and this
4 would be the basis of legislation hopefully, the
5 Commission's work here. Yet, you know, maybe you
6 have in other cities, you have really got down and
7 talked to the average person. But, you know, I sort
8 of see a distorted picture you are getting. Not
9 because of your fault, but that's just the way
10 that, you know ---

11 THE CHAIRMAN: Why are you
12 so apprehensive that we are going to draw sweeping
13 conclusions from a particular sample? I mean, why
14 don't you --- we take each thing that comes before
15 us in sequence. We have heard from pharmacists, we
16 have heard from others. This is a particular popula-
17 tion. The others acknowledge the limitations. What
18 makes you think we are going to draw conclusions of
19 a general character --- but this in itself has
20 significance. I mean, there is no reason why we
21 shouldn't look at this study for what it is worth
22 and the group it deals with.

23 THE PUBLIC: Right.

24 THE CHAIRMAN: But you
25 shouldn't infer from that that we are not having
26 contact with a much larger group --- a wider range of
27 people. I mean, you know, don't be apprehensive that
28 we are getting just a little picture here and a little
29 picture there. It has built up slowly, of course it
30 has. We can't get the whole picture in one day. But

1 it so happens that in Windsor we are getting facets and
2 aspects and emphases that we haven't got somewhere else
3 and this builds up the composite picture. That's why
4 we have been out on the road to twenty-three cities.
5 I mean, we haven't met this study yet and we haven't
6 heard certain problems. For example, this is the
7 first time we heard about the prescription insurance,
8 and the point of view from that side of the table. Now
9 admittedly that may be a matter of limited concern to
10 many in the room at this moment, but it is part of the
11 general picture we have got to develop, because I
12 repeat, we have been given --- we have been asked to
13 look at the full range of medical drug use, of psychotropic
14 drugs and substances, so don't be --- let's just, I mean,
15 look at this study and get the benefit we can from it,
16 and not think that we are going to run away and say ---
17 I mean I don't see how the authors could be more
18 straightforward in emphasizing the sample.

19 THE PUBLIC: I mean, are you
20 getting a study like this done in high schools? Has
21 there been any work done like this or were they stopped
22 as they were by the Windsor School Board?

23 THE CHAIRMAN: Well, there
24 have been a lot of studies, quite a number of studies
25 done on high school and college populations involving
26 these correlations, questions and motivations, backgrounds
27 and so on. We ourselves are carrying out a national
28 survey on non-medical drug use and we have just com-
29 pleted a college population survey. And I can tell you
30 we have had a lot of contact. I mean, we shouldn't be

1 complacent about any of our source of information, but
2 we do feel a bit confident about having met the college
3 students of this country and having had their point of
4 view pretty fully expressed to us. So I wouldn't ---
5 but it doesn't mean that your observation isn't well
6 received by us, because we need --- we have to be
7 cautious about the significance of certain things, but
8 this is a particular study, let us look at it. We
9 ourselves are aware that the level of the use here is
10 very high. I mean the percentage levels on the drugs ---
11 well, we know, we have some statistical knowledge at
12 the moment.

13 DR. LEHMANN: But suppose we
14 were to look at alcohol, wouldn't we be delinquent in
15 our duty if we would not look at alcoholics?

16 THE PUBLIC: Oh, right.

17 DR. LEHMANN: And only the
18 social drinker?

19 THE PUBLIC: I wasn't
20 attempting to cut down this particular survey because
21 I know these men are, you know, they are academics,
22 they sound academic, but what I mean, from what I have
23 read in the paper, any work done on drugs always seems
24 to be dealing with abnormalities, the type that had a
25 bad trip in LSD. While the percentage of LSD users
26 and the percentage of marijuana users that are in that
27 type of situation is so small. That doesn't affect the
28 average kid. The average kid is probably turned off
29 by a newspaper article along these lines. What I am
30 concerned about is the communications links between a

1 Commission like yourself and the average kid, you know,
2 a kid who works part time and goes to high school or
3 college. I don't know if he feels he can get across to
4 you. I know it is not all your problem, but there is
5 one thing that impressed me with the proceedings,
6 other things --- other drug problems.

7 THE PUBLIC: Can I ask a
8 higher question than that? No, I didn't mean higher,
9 I meant more broad. He has got a really good point
10 there, I admit that. What is this Commission --- let's
11 talk about marijuana right now. What will the Commission
12 base its recommendation on as to the illegality or
13 legality?

14 THE CHAIRMAN: Well, you
15 keep asking these questions. You don't provide us
16 with enough insight into your own views. We are here
17 to inquire.

18 THE PUBLIC: No ---

19 THE CHAIRMAN: You made the
20 point once now. We cannot express our conclusions when
21 we are here to listen and learn. This is supposed to
22 be a hearing, you see. We are not to prejudice the
23 hearing by expressing our view prematurely. You
24 understand that?

25 THE PUBLIC: I am sure you
26 start out with something absolute as to what this
27 Commission is, or are you just wandering around the
28 country? All I am asking is, are you going to say --- are
29 the researches being done into the physical aspects as well as
30 the social aspects? As far as I know, they don't even

1 know what the intoxicating agent of marijuana is yet.
2 Now are you going to base it on whether it is good or
3 bad for the person or whether or not people are using
4 it, that they will have to let them do it or there
5 will be an uprising?

6 THE CHAIRMAN: These are very
7 good questions, very fundamental questions. This is
8 the kind --- we are trying to determine as part of
9 our task on what the decision should be on each of the
10 issues, and what is your view on that particular issue?
11 Should we ignore the question as irrelevant harm?

12 THE PUBLIC: No.

13 THE CHAIRMAN: Should we ---

14 THE PUBLIC: You are the guys
15 that are doing the inquest.

16 THE CHAIRMAN: We are not
17 here --- we are here to learn.

18 THE PUBLIC: If you want to
19 start off like something --- like this Commission is to
20 see --- okay, if we want to get off that trip ---

21 THE CHAIRMAN: It is better,
22 it is better that you get off it because you have
23 obviously got ideas contributing to us in our under-
24 standing, so why don't you state what you think we
25 should do.

26 THE PUBLIC: Okay.

27 THE CHAIRMAN: Instead of
28 asking me and applying your views and questions.

29 THE PUBLIC: I want to know
30 who I am talking to. I don't know anything about you

1 people. I don't know the purpose ---

2 THE CHAIRMAN: We don't know
3 anything about you but we are very glad to listen to
4 you

5 THE PUBLIC: I would like
6 to know who I am talking to. Now, could you also
7 answer me as to how this Commission was drawn up and
8 as to why you feel that you were the best possible
9 people to look into this?

10 Like, has anyone tried
11 marijuana in this Commission?

12 Now, I think that is a valid
13 question. You just can't --- I know you are probably
14 going to give us the analogy of a doctor, broken leg,
15 and you know what a broken leg is about, but that's,
16 you know --- if you really want to get into it and it
17 is a big problem in the country, so like I don't see---
18 except for the people in the secretarial there or on
19 the chair ---

20 THE CHAIRMAN: That is
21 reassuring to you, is it?

22 THE PUBLIC: Yes. At least
23 there is some ---

24 THE CHAIRMAN: They are also
25 excellent scientists.

26 THE PUBLIC: Probably, yes.

27 THE CHAIRMAN: And that's why
28 they are there, not because of the length of
29 their hair.

30 THE PUBLIC: Are they good

1 people too? That's what counts. Not whether they
2 have a good mind, it's how they relate to people.
3 That's what your job is, to relate to people, and if
4 you can't come across to us, then you are useless. If
5 you can come across and say what your position is,
6 and "yeah we want to get into it and maybe it is a good
7 idea, so let's hear what you have to say, fine. "It's
8 got to be a two way street, like you just can't come
9 here and ask questions and say "Okay, what do you people
10 think?" and people jump up and say, "Legalize it or
11 illegalize it", you have to give your side too. We
12 have to hear your position.

13 I was just wondering if, like,
14 my previous question was will it be just like --- will
15 enough people want to legalize it or is there physical
16 work being done on it?

17 THE CHAIRMAN: There has been
18 research done into the effects of the drugs and we are
19 going to disclose in our interim report our preliminary
20 conclusions on the effects of the drugs, and I think
21 that is --- in other words, we will disclose our
22 assumptions at this time concerning the effects of the
23 drugs and not only marijuana. And it is quite a
24 substantial part of the report.

25 THE PUBLIC: Could I make just
26 one last closing remark?

27 THE CHAIRMAN: Yes. Don't
28 leave.

29 THE PUBLIC: Heavens.

30 The Commission is find about

1 asking about marijuana and drugs and that kind of thing.
2 I think what you should be asking --- maybe the
3 Commission isn't big enough, you should have fifty
4 people and fill a football field or something, but the
5 thing you should be asking is not only why people are
6 using drugs but like why people are going to hell on
7 it and why they are telling parents to go to hell.
8 It doesn't really make any difference
9 whether you legalize it or illegalize it. If you
10 legalize it people are going to turn to something else.
11 I know this is a way out of your field.

12 THE CHAIRMAN: No, it's not.
13 You are absolutely right and we agree with you there
14 and we are asking these questions and we are getting
15 answers to those questions. We are asked to inquire
16 into what are the reasons, what are the other factors.
17 We are. It is a bit of an advantage, and I appreciate
18 this, because you of course haven't been with us all
19 across the country, but we have heard a lot about the
20 larger picture. I mean, I say that to you to give you
21 confidence.

22 THE PUBLIC: Will this be
23 included in the report to us, to the whole youth
24 culture?

25 THE CHAIRMAN: Yes. We are
26 going to give our views at this stage, what we have
27 heard about cultures yes.

28 THE PUBLIC: Okay.

29 THE CHAIRMAN: I appreciate
30 your concern. You know, you see one day or one morning,

1 but I think we have really been exposed to a very
2 wide range of opinion. Anyway, you will judge when the
3 interim report comes out

4 THE PUBLIC:

5 (portion inaudible)

8 THE CHAIRMAN: Another year.

9 THE PUBLIC: I thought it
10 was supposed to be in February or something.

11 THE CHAIRMAN: The interim
12 report is to come out very soon and then we have to
13 make a final report at the end of next year, this
14 ensuing year.

15 THE PUBLIC: Okay.

16 THE CHAIRMAN: All right?

17 Thanks.

18 The gentleman at the micro-
19 phone?

20 THE PUBLIC: I would like to
21 --- I think I can describe myself as a newcomer into
22 the drug scene and, well, I am not afraid to admit that
23 I smoke grass and like, I have been smoking grass for
24 about two years, and when I first started smoking it,
25 like the first time I smoked it I guess it was sort
26 of an experiment. I did a lot of reading on it and
27 everything and I wanted to find everything out about
28 it, because people have told me things about it and I
29 just thought that I might get something out of it. So
30 I tried it and I liked it so I kept on using it, and I

1 could say that in the past two years that my thinking
2 has been drastically changed about a lot of things, and
3 it has provided for me a lot of hassles which I don't
4 like, but as far as like effects on myself, like I can
5 say that I am not dependent upon it at all, and that I
6 could go without it, and I think it should be legalized.

7 THE CHAIRMAN: Thank you.

8 THE PUBLIC: Well, I have
9 nothing to do with that. I was just wanting to talk
10 about the encounter groups that these people are into,
11 as I am a former member of one of them and I took that
12 study that they were doing there, but like I got into
13 it because I was a suspected user at a high school and
14 I got fingered in a letter to the principal and rather
15 than turn us into the local authorities, they decided
16 that, you know, maybe we should get into a situation
17 where it could be therapeutic. Now I found that by
18 going to these groups, the sort of methods they use to
19 treat people and that, the idea behind it is really good
20 because it is sort of like trying to show people how to
21 blot away all their middle class hang ups and all kinds
22 of other things which they call fronts, and sort of
23 letting you be yourself more than, you know, getting
24 hung up with things in high school and that, and after
25 going to these groups and getting into the things that
26 they do down there, I found that I can use the methods
27 that they use to relate to people more, you know, to
28 actually say, well, you know, "he is a bank manager,
29 get into what a bank manager should be", and see, maybe
30 you can find the good points of him, and mainly this

1 is what is happening at the A.R.F. But there is that
2 one point you brought up of group dependency. Like I
3 found that while I was there I wasn't using it outside
4 the group, I was just using it inside the group with
5 the people who were in the group and after I left I
6 sort of was thinking, well "can I do it with other
7 people, or just the people I was in the group with?" and
8 I found that sort of, if you just don't jump right
9 into it with people, if you just sort of, you know,
10 lay back and feel around and find out where the person
11 is standing, you know, is he saying "You are just a bad
12 person because you have got long hair and smoke grass",
13 or you know, "Does he have his good points?" And if a
14 person will give you a chance, you could get into it,
15 you know, and relate to that person. I think, you know,
16 that with the A.R.F. they are doing a good job and it
17 is a very good idea. I think more people should get
18 interested in that and more plans should be set up
19 across the country. But the thing is that you have to
20 have a certain time limit when you are going to quit
21 and get out of the air of meeting, of what you are doing
22 down there.

23 THE CHAIRMAN: That is a very
24 interesting point because we have heard about the group
25 dependency and dependency of having to remain in the
26 group and not being able to carry on outside of it.
27 Have you seen a successful transition?

28 THE PUBLIC: I have seen more
29 than one person get a lot out of those groups but I
30 have seen a lot of other people who have dropped out,

1 | who have just gone back to what they were into before.
2 | But really those are the type of people who don't want
3 | anything else. They are happy with being dope addicts.
4 | So they just drop out of the groups and go back to
5 | where they were before, but I have seen a lot of people
6 | come out of these groups with a better attitude towards
7 | life and what is happening outside their own little
8 | world, say suburban high school or something like that.
9 | It seems to broaden their world opinion.

10 | DR. LEHMANN: Have you overcome
11 | your dependency on the group?

12 | THE PUBLIC: No I have not --
13 | yes, I have not been to the group for about seven
14 | months. I go back once in a while just to talk to
15 | people because I met a lot of good people there. And
16 | I think that whereas Steve was talking, his getting
17 | into a lot of good things, because high school teachers
18 | are getting into the area of finding out what is
19 | happening to the kids, rather than just being an
20 | authoritarian figure, teaching a bunch of baloney to
21 | kids and things like that. He is actually getting into
22 | it with them and saying, "Look, I am a person too and
23 | I can do it with you, and try it with your parents and
24 | see if you can get into it with them." And it's really
25 | great, I think my teachers ought to get into it too.

26 | DR. LEHMANN: Do you think
27 | other kids are more convinced of it, do they know about
28 | it, do they like it or are they suspicious of it?

29 | THE PUBLIC: Well, there are
30 | a lot of people suspicious of it mainly because it is a

1 Government organization and simply because they think
2 there is a chance they could get busted, but I think
3 that if they talk to people that were in the groups
4 before, they would find out there is nothing wrong with
5 it. But that is the only reason that I can see why
6 people would not want to.

7 DR. LEHMANN: Do you talk to
8 them, do you make propaganda for it?

9 THE PUBLIC: Well, I don't
10 say, "go to A.R.F., it's a good thing." If somebody
11 asks me just as a person who has been there, what it
12 did for me, I would tell them just exactly what
13 happened to me. But I don't go tell people, you know,
14 to go to the place. If they want to, they will. You
15 can't make people go to these places. They have to do
16 it on their own.

17 DR. LEHMANN: No, but you
18 tell somebody else how good a trip on grass might be.
19 You might tell somebody how good a trip this might be.

20 THE PUBLIC: All right, I have
21 told people that a lot of good had happened to me.

22 THE PUBLIC: Yes, I have
23 something to say to relate back to something a couple
24 of other people were saying, and it has to do with that
25 interim report that was coming out, and John Turner was
26 down to the University, either the tail end of February
27 or the first week of March, and he said at that time
28 the only thing that was holding up the interim report
29 was translation problems, and I notice you were chatting
30

1 away madly in French with the little girl there, so I
2 can't really see a three month's wait because of
3 translation problems, and there have been all kinds of
4 ugly stories floating around how the Federal Cabinet
5 is locked into supporting whatever recommendations this
6 Commission might come forward with, so we have somewhat
7 of an interest in seeing which recommendations this
8 Commission does come forward with. So my only comment
9 to that is that I hope that you people are in the
10 position where you are not forced about by some of
11 those pressures.

12 THE CHAIRMAN: No, I made a
13 longish statement yesterday in London in response to a
14 similar question, and the facts --- it is understandable
15 that you should be this concerned, and the facts are
16 that we started to write it after about six month's
17 inquiry. We felt that we needed a minimum of six
18 months hearings as a basis for the interim report, and
19 we knew that in the way of this whole question was
20 developing, the feeling of perception on it, that we had
21 to give it as good an analysis as we possibly could at
22 the interim stage, so we spent about three and a half
23 months writing it, and it was completed and bound and
24 ready since the beginning of April. And we offered it
25 to the Minister and we were hopeful the translation
26 would come on fairly soon after that. We had been
27 working on the translation to some degree concurrently,
28 but as you know, it is never completely concurrent because
29 as you revise, sometimes extensive revisions, it has to
30 go back and be reworked into French and there is an

1 inevitable lag. We offered it to the Minister in English
2 and he said that he required it in both languages, and
3 certainly I would not presume --- although we regret
4 the delay very much --- would not presume to criticize
5 that decision for obvious reasons. I mean, this is
6 and this is the law
7 the Government/and it is the practice now that it
8 should be in both languages, and it certainly could not
9 be tabled in the House. In any event, we have had the
10 English version in our hands since the beginning of
11 April and nobody in the Government knows anything about
12 it, although there has been much speculation about it.
13 I think we have been very successful, I don't know how,
14 in maintaining our security. We have now finally
15 completed the French version --- that is, the translation
16 in French and the printing of it is being completed
17 now. It is just a matter of a few days and we will be
18 in the position to deliver both languages to the Minister
19 in a very few days. When it will be tabled we do not
20 know, but we believe it will be within a very few
21 short time after it is delivered, and we hope that
22 will be the case. But this is the simple, truthful
23 factual story of the report. It is a report of
24 approximately 600 pages and we worked as hard as we could
25 on it and we wish we could have got it out earlier, but
26 I don't have to tell you how difficult the question of
27 the whole thing is and what a great responsibility it
28 is, and we have to look at all of the drugs and try to
29 put it on an overall perspective. And as it has turned
30 out for the very reasons that have been stressed here
this afternoon, the translators have found themselves

1 with a very great challenge because this thing has
2 as you can see and feel social and cultural implications
3 of a very profound nature. First of all, we were
4 concerned with the technical effects of the drugs. We
5 have a chapter of 250 pages on drug effects. This in
6 itself was a great translation job but then all the
7 questions of cause and the subject of the drug sub-
8 culture in another language, in another culture, how to
9 express or to adequately translate the nuance of inter-
10 pretation, philosophic and cultural trend. It turned
11 out to be quite a formidable job. There is not even a
12 word "establishment" in French. So it has turned out
13 that they have to almost develop in some sense, the
14 resources of the French language to convey these nuances
15 in English. So that is the simple, unvarnished story.
16 No one knows what is in it and there is no pressures
17 upon us and no skulduggery and we hope now that in a very
18 few days it will be out and we are printing a pocketbook
19 edition of it well in advance which is being set up, and
20 we hope will be available for the public very soon, after
21 it is tabled in the House. This is the full complete
22 story and we wish that we could have got it out earlier,
23 but we have done our very best on it.

24 Thank you.

25 Now you had not completed your
26 statement and we interrupted you--excuse me, gentleman
27 at the microphone?

28 THE PUBLIC: I have a question
29 to ask.

30 THE CHAIRMAN: Right.

1 THE PUBLIC: In a study that
2 deplores the lack of communication between parents and
3 their children, between children and their peers, in
4 certain groups, I find it very distressing to see the
5 sequence of events when this is set up, and if I'm not
6 correct, I am very sorry, really sorry that Mr. and
7 Mrs. Newton Smith could not be here, but if I am not
8 correct, you will have to correct me, what happened
9 was that the Board of Education said no, you can't do
10 our study. I would like the people who are involved
11 in this study to relate to me why they said no. And
12 are the reasons --- not just the nice public reasons,
13 if you've really got guts you'll say what you think are
14 the real reasons, and secondly are those reasons, are
15 they symptoms of the same kind of lack of communication
16 that you deplore in your study?

17 MR. CHANDLER: I tried to
18 pass the buck to Linda, but she said no, you can handle
19 it.

20 Okay, the press reports I
21 think did state the official given reason and the
22 unofficial given reason in both news items and editorials
23 in the Windsor Star. A great deal of press coverage
24 was given in the process. Perhaps I might very
25 briefly summarize what took place. The request went to
26 the Windsor Board of Education for approval and it was
27 turned down by the Trustees of the Board for the given
28 reason that it would interfere --- it was a heavy load
29 on the administration and would interfere with daily
30 studies. So we had deliberately set up the project

1 so that the research team would take on all of the
2 labour, all of the paper work, all of the administration
3 and study and about 20 minutes of school time would be
4 needed. There was a good deal of very heated discussion.
5 There was a motion for a member of the team who was
6 present at the meeting to be heard from in order to
7 answer questions. This motion was defeated. And
8 because of the public controversy over it, it went to
9 a meeting of the Research Group and the members of the
10 administration who came up with an acceptable compro-
11 mise for the study, and this was presented to a
12 subsequent meeting of the Board and this too was turned
13 down --- for no given reason. I think the Windsor
14 Star terms it "no objective reason." Now, I hope I have
15 the guts. I think first of all the topic was too hot.
16 One member said this off the cuff at a meeting, and
17 another talker, a member of the other side/^{said} that had it
18 been a topic of psychoanalytical science, perhaps it
19 would have been acceptable/^{which} leads me to believe it was
20 because the topic was at that time too controversial.
21 On the other hand, in order to be fair, the timing
22 for the Board of Education may have been very inopportune
23 because of a number of other studies completely unre-
24 lated to this one that took up time of a school and in
25 that case this study on top of a whole lot of others
26 certainly would have, perhaps been the straw that
27 broke the camel's back, in these terms. The Board of
28 Education to use their words; "left the door open." They
29 have indicated that they would be interested in a
30 proposal presented to them at another time.

1 THE PUBLIC: Is this a public
2 proposal or non-public proposal, a private one that
3 won't be released, that the public won't have knowledge?
4 What I'm trying to refer to is, was the Board of Education
5 scared that people in this City would find out just
6 how many people are doing up at night and at noon and
7 in the morning?

8 MR. CHANDLER: Well, this
9 study was not designed to get that information, but
10 perhaps there was fear that it was going to get at
11 that kind of information. The agreement with all
12 research studies is that there would be agreement between
13 the researchers and the cooperating agency. This is
14 not a policy just of the School Board but certainly of
15 the University of Windsor School of Social Work. I
16 agreed with both parties to the project to anything
17 that was made public. For example, the Addiction Research
18 Foundation was consulted before the preparation of
19 this brief in order to get their approval for this.
20 I think that tempers got very hot on all sides at the
21 time. It was difficult for everyone involved to be
22 objective and the elected officials of the Board saw
23 fit to turn it down twice. We didn't agree with them,
24 but on the other hand they are elected to administer
25 the affairs of the Public School Board and it was their
26 decision to make and they made it, but also they have
27 left the door open for a study at some future time.

28 THE PUBLIC: Mr. Secretary,
29 here is an opinion that you can record. In this City,
30 we have a School Board that will not face up to what

1 makes people grow and go, and instead wants to teach
2 nothing but Latin declensions and history of Modern
3 Europe, and I am sick and tired of it.

4 And believe it, because people,
5 you know, it is going to be --- sometimes when drugs
6 are going to be --- you know, it's not going to be
7 just some taboo thing when inquiries come about, it's
8 going to be inquiries some day about why people aren't
9 using it sometimes. We are getting too big in this
10 world, it has been said before and I don't want to
11 get into some macro sociological thing, that is not
12 my field. But, if you are going to have any kind of
13 "rap," is the right word, between two people, you have
14 got to have a listener and you have got to have a
15 talker, and the listener has to become a talker and
16 the talker has to become a listener. And as far as
17 I am concerned, the Board of Education never bothered
18 to listen.

19 Thank you.

20 THE CHAIRMAN: Mr. Chandler,
21 do you feel --- we have sort of had a lot of ideas ex-
22 changed in the course of your presentation. Do you
23 feel that you have had an opportunity --- adequate
24 opportunity to present this thing? We are going to
25 study it and look at it but is there anything you
26 think you should draw our attention to in connection
27 with the study? In effect, I have just slightly lost
28 the thread of where we are in relation to your study.
29 You know, I have got a sense of it but I want to make
30 sure that there isn't something more you should tell us

1 about it.

2 MR. CHANDLER: I would like to
3 ask ---

4 THE CHAIRMAN: Yes, I meant
5 the whole group.

6 MR. CHANDLER; And if there
7 is anything they would like to add, particularly Linda,
8 who as I said, along with Mr. and Mrs. Newton
9 Smith, did a lot of hard work on the study.

10 MRS. POPP: I just think it
11 is important for them to take it for what it is.

12 THE CHAIRMAN: A very, very
13 special character of the sample.

14 MR. KROEKER: One point in
15 connection with what Mrs. Popp is saying, there is a
16 connection to getting at basics and facts and at things
17 you want to, and I think this group here along with
18 others would like some encouragement for some of the
19 difficulties they have encountered along the way. I
20 think by way of support by many others, and I think it
21 is necessary now and I think it is going to be necessary
22 in the future.

23 THE CHAIRMAN: Well, we are
24 certainly very grateful to groups like this in
25 the country who put this kind of work --- the amount of
26 work and effort into studies of this character. And
27 we certainly express our appreciation to you for the
28 work. And if you have anything further you would like
29 to add to it, I would appreciate it if you would drop
30 us a line on it.

Thank you very much indeed.

I call now on Mr. Bernard Newman.

THE PUBLIC: Mr. Newman passed me on his way out and he apologized but he had to go.

THE CHAIRMAN: Is he coming back?

THE PUBLIC: I don't know. He indicated to me that it wouldn't be possible. He was in a real bad bind.

THE CHAIRMAN: It is unfortunate.

I call now on Mrs. Mailloux who is going to present the brief on behalf of Dr. John Spellman, University of Windsor.

MRS. MAILLOUX: This brief, Marijuana and the Laws, is submitted to the Committee of Inquiry into the Non-Medical use of Drugs - Government of Canada, by J. W. Spellman, Ph.D. Dr. Spellman is currently Professor and Head of the Department of Ancient Studies at the University of Windsor.

The first few pages deal with the introduction of Dr. Spellman of the report in 1968 by the Advisory Committee on Drug Dependence in the United Kingdom entitled Cannabis. There is a short section which discusses the philosophy of control. That issue is central to any meaningful discussion of legislation which considers punitive action by the State against an individual for the use, possession, or sale of marijuana.

I will leave it to the Committee

1 to read that section and go on to Dr. Spellman's
2 section.

3 Section one is regarding
4 behaviour. The quotation taken from John Stuart
5 Mill's essay On Liberty is an appropriate one and
6 indeed the phrase "self-regarding" as a type of
7 behaviour which is outside the legitimate purview of
8 the punitive power of the state derives from that
9 essay. The concept of liberty, expressed by the
10 Committee in paragraphs fifteen and sixteen of the
11 Report, is widely held, crucial, and a monstrous
12 perversion which would render that concept impotent.
13 The statement of the Committee is as specious as it
14 is frightening in its implications. "If, generally
15 speaking, everyone is entitled to decide for himself
16 what he will eat, drink or smoke, the fact remains that
17 those who indulge in gross intemperance of almost any
18 kind will nearly always become a burden to their
19 families, the public authorities, or both." The
20 acceptance of the thrust of this argument is fundamental
21 in establishing a legitimate right of the state to
22 intervene in the exercise of personal liberty, which it
23 presently does in the matter of marijuana to the point
24 of deprivation of practically all liberties, through
25 the act of incarceration.

26 Section two deals with the
27 inherent dangers of legislation. The thrust of Mill's
28 argument has become even more important in today's
29 society, which, it seems, increasingly turns to legisla-
30 tion as a panacea to enforce social behaviour desired

1 by one group or another. Every piece of legislation is
2 by definition a restriction upon liberty, since it
3 limits the options available in a free choice. It is
4 now argued in the Cannabis report that if we are
5 entitled to decide for ourselves what we shall eat, drink
6 or smoke, some of us will indulge in gross intemperance
7 and thereby become a burden to our families or the
8 public authorities, or both. On the basis of "gross
9 intemperance" by some, all of us shall be liable to
10 punishment by the State, and since all acts are subject
11 to gross intemperance, the State, by this reasoning,
12 shall have the right to deny liberty in all areas.

13 Section three deals with the
14 burden of proof. Implicit in this argument is the
15 assumption not that liberty inherently resides in the
16 individual, and that he surrenders only that portion,
17 and only to that degree, which is necessary to guarantee
18 maximum liberties to all; but rather that liberty
19 resides in the government, and that it surrenders to the
20 individual only that amount which it considers desirable
21 for his welfare. The present discussion on Marijuana
22 is illustrative. Some argue that the evidence is
23 conflicting, and even though it cannot be definitely
24 proven that marijuana is harmful, there is a possibility
25 that further research might show that it could be. And
26 until it can be shown not to be harmful, those who
27 possess or sell it, will be deprived of their liberty.
28 This is a curious and perverse position.

29 The government has refused to
30 accept the burden of proof, which in this case would

1 require that they present a clear, convincing and
2 compelling case, indicating not simply desirability
3 or rationality, but the necessity for the present
4 legislation in terms of the injury that is casually
5 related to the life, safety or property of others.

6 The language of Justice Goldberg in Griswold vs.

7 Connecticut is a sound concept of law, and I quote,

8 "Where there is a significant encroachment upon

9 personal liberty, the state may prevail only upon

10 showing a subordinating interest which is compelli-g,

11 the law must be shown 'necessary' and not merely

12 rationally related, to the accomplishment of a permi-

13 ssible state policy." I submit that there is no case

14 that the government has made, or can make, on the

15 basis of the evidence available, which can demonstrate

16 the 'necessity' for the present legislation. In the

17 absence of such a case, I suggest that there is no

18 moral alternative except to rescind the legislation

19 forthwith, to free those it has wrongfully imprisoned,

20 and make restitution to those whom it has punished.

21 (applause)

22 Section four is entitled

23 "How Dangerous is 'Dangerous'".

24 It is, I trust, unnecessary

25 in this submission, to refute the various unsubstantiated

26 allegations which have been made in an attempt to show

27 a causal relationship between marijuana and opiate

28 addiction, crimes of violence, psychotic illness, and

29 similar myths, which have long been popular. Every

30 major report, including those of the LaGuardia Report

It is insufficient for a

When estimates put the number

of persons in Canada using marijuana into the hundreds of thousands, and in all levels of society, we should expect that at least some of these alleged dangers would have been extensively documented and proven. At the very least we might have expected a relationship

1 to be shown between automobile accidents and driving
2 under the influence of marijuana. Such a relationship
3 has been tragically clear with alcohol. The evidence
4 of the Washington experiment involving the Department
5 of Motor Vehicles and Departments of Pharmacology and
6 Psychiatry, at the University of Washington, dispels
7 this assumption also.

8 I quote from their report,
9 "Driver simulator tests show that an experienced
10 marijuana smoker who is experiencing a social high
11 from smoking marijuana is no more likely to make
12 driving errors than when he is in a normal physiological
13 and psychological state. In contrast, he is signifi-
14 cantly more likely to make driving errors when he is
15 experiencing alcohol intoxication than when he is in a
16 normal state or when high on marijuana." What then,
17 is the evidence and how extensive is it on which the
18 government presumes to make its allegations of "Danger"?

19 Number five deals with the
20 experts. We cannot ignore the fact that this legisla-
21 tion is supported largely by official agencies which
22 are supposed to enforce laws not make them. We have
23 come to the rather incredible stage of narcotics and
24 police agencies telling us what kind of laws we should
25 have. When the police tell the government what kind
26 of laws to make for the people in any society, we may
27 presume an unhealthy climate for liberty exists.

28 It is important for us also
29 to examine the credentials of the alleged authorities
30 in this field. Too many are assumed to have a special

1 competency because they are police officials, narcotics
2 officers, physicians or psychiatrists. Most of them
3 have never done even the most elementary degree of
4 research despite the somewhat impressive positions
5 they may hold. There are many examples of such
6 experts. Their qualifications must be rigorously
7 scrutinized if they claim to speak on the authority
8 of their own knowledge. It is not sufficient to say
9 that some experts say one thing and some another and
10 we have to wait until they agree. There are scholars
11 and physicians and others who have done considerable
12 research. It is long past time that we give the
13 results of their research the important consideration
14 it deserves.

15 Section six deals with
16 treatments. Nor have I any sympathy for those who in
17 their misguided benevolence see this as a medical or
18 psychiatric problem. There is absolutely no medical
19 treatment for marijuana consumption since it produces
20 no disease. Why we must declare that getting high is
21 an illness involves some curious reasoning. Indeed,
22 it is even legitimate to question whether marijuana
23 can properly be called a drug. The most common deno-
24 minator of drugs is that they are substances used
25 therapeutically to cure or relieve an illness.
26 Essentially, marijuana is an herb having the character-
27 istics and horticulture of that plant class. It is
28 claimed to be a drug largely on the basis of its
29 quality to alter perception slightly. Further, there
30 is no recognized therapeutic technique for treating an

1 otherwise normal person who uses marijuana. The only
2 other option is to say that by definition anyone who
3 uses marijuana will be automatically considered
4 mentally ill and in need of psychiatric treatment.
5 That would be an incredible and unviable definition
6 of mental illness and would largely demonstrate how
7 absurd this thing has become.

8 Section seven deals with
9 adding another vice. It is sometimes argued that
10 there are enough vices in our society already and
11 that we should not add another one. For example, fine c
12 imprison those who possess or sell marijuana. We may
13 pass over the philosophical and ethical problems
14 involved in labelling a practice as a vice, and
15 indeed the assumption that a vice for one person is
16 necessarily a vice for all people, but we cannot
17 avoid the political implications of this argument.
18 To sustain it, we must agree that the government is
19 the best judge of what shall constitute a vice; that
20 all practices labelled by the government as a vice shall
21 automatically be subject to the police powers of the
22 state, without further justification; that even
23 personal and fundamental liberties may be abridged in
24 the supression of such vices, and more importantly,
25 that while the majority are entitled by their position
26 of political power to their vices, no such corresponding
27 right shall be held by the minority. (applause)

28 I submit that it is not within
29 the moral prerogative for the majority of society to
30 indulge itself in demonstrated dangerous practices

Section nine, dealing with the costs of the law in 1968, there were nearly fifteen hundred convictions in Canada for marijuana

1 offences. Sentences ranged from small fines to over
2 ten years imprisonment. There were nearly three
3 thousand new marijuana cases brought to the attention
4 of the Federal Government in that year representing a
5 figure nearly double that of 1967, but recognized by
6 the government as being only a fraction of the total
7 number of marijuana users in this country. Over half
8 of those arrested were over 21 and out of the total figure
9 of 2,830, 2,712 had no previous narcotic or criminal
10 record. They now have both. If the figure of 10,000
11 new cases in 1970 represents only a fraction of
12 marijuana users, as it undoubtedly does, it is not
13 unreasonable to suggest a figure of at least 100,000
14 marijuana users in Canada and a more accurate figure
15 would probably be very much higher. From this very
16 practical perspective, it must be obvious that the
17 laws are not acting as a meaningful deterrent and that
18 the effective enforcement of this legislation would
19 require major taxation for a dramatically increased
20 police force, narcotic bureaus, judiciary and prison
21 construction programmes. With all the ecological and
22 social problems facing this society, it would be
23 absurd to continue to pay the financial costs of the
24 present legislation.

25 We should be aware that the
26 present marijuana legislation is a very heavy burden
27 to this society. All economic costs of this legislation
28 must be financed through taxation. No reliable estimate
29 has been made of the expenses involved, but it must be
30 at least in the hundreds of thousands including only

1 salary and equipment costs.

2 The next is search and seizure

3 One of the most serious consequences of this legisla-
4 tion is in the field of search and seizure. Of all
5 the rights in a civilized society, the right of
6 privacy is one of the most valued, the right to be
7 left alone. There is something very terrifying about
8 police forcibly entering the privacy of one's home.
9 Only when there exists what the American Justice
10 Holmes called a clear and present danger to society
11 should we even consider allowing this most brutal
12 of state actions. I do not believe that we can
13 justify the abridgment of such fundamental liberties
14 on so slight a case as has been made against marijuana.

15 The next section deals with
16 human costs: To the financial costs are added the
17 human costs --- a law which stigmatizes as criminal
18 citizens who have committed no injury against anyone
19 but whose lives, nevertheless, may be scarred by that
20 criminal record, whose employment opportunities may
21 be drastically reduced denying society valuable
22 talents, college students who may not only be deprived
23 of part of their liberty but at a time when educational
24 and career choices are being made. The Federal reports
25 show that an overwhelming majority of those convicted
26 are imprisoned /and the fondest and most humane hopes of the government
27 will not change that fact as long as the present
28 legislation exists. If there is to be any effective
29 enforcement of the law, there must be strong social
30 condemnation of the act to serve as a restraining effect

1 This is not now the case and it is even less likely
2 to be in the future. Put very plainly, the law is
3 simply unworkable as well as being unjustified. It
4 cannot be enforced and it would be political suicide
5 for a party to attempt it.

6 In order to justly sustain its
7 morality and correctness in retaining legislation
8 which exacts such high costs in economic, social and
9 personal liberty, this society must make a very
10 compelling case in its defense. It is not enough to
11 talk smoothly about public welfare or the interests of
12 public health, when the facts appear to show that it
13 is the legislation itself which is the greatest danger.
14 A civilized society does not jail persons on the
15 possibility that they may be doing something dangerous
16 but only on the certainty that they are. While I
17 believe that there are circumstances under which it is
18 unwise and even stupid to ingest marijuana, I do not
19 believe we have the right to imprison persons for
20 merely being unwise or stupid. I am not here arguing
21 that marijuana is harmless and innocuous nor do I think
22 that there is a burden of proof to demonstrate such an
23 extreme proposition. It would be difficult to prove
24 that about almost any substance. Yet the Cannabis
25 report states not that there is a little evidence, but
26 "There is no evidence that this activity is causing
27 violent crime or aggressive anti-social behaviour, or
28 is producing in otherwise normal people conditions of
29 dependence or psychosis, requiring medical treatment."

30 I come to the conclusion

1 from reading Dr. Spellman's recommendations. At the
2 very least I recommend the following should be
3 implemented: first, that the present legislation
4 on marijuana should be rescinded. Second, that it
5 should not be illegal for persons over the age of
6 18 to possess or sell marijuana. Third, that the
7 provisions of the law with respect to police power of
8 search and seizure be denied in marijuana cases.
9 Fourth, that persons imprisoned on marijuana convictions
10 be released forthwith; that their criminal records be
11 expunged in this matter and that special provisions be
12 made to aid them in educational and employment
13 opportunities. Fifth, that funds be made available for
14 on-going research and educational programmes to indicate
15 more precisely the nature and effects of this
16 substance.

17 I believe that the evidence
18 merits these conclusions. A civilized and moral society
19 cannot afford the existing legislation because of its
20 abridgment of fundamental liberties, its excessively
21 high economic costs, its disruptive consequences for
22 society especially in the lower socio-economic strata;
23 its tendency to encourage rather than reduce crime;
24 because it has not, and cannot, be effective and because
25 the evidence available will not support a compelling
26 case to justify the inherent evils or the present laws
27 on marijuana.

28 THE CHAIRMAN; Thank you,
29 Mrs. Mailloux.

30 (Applause)

1 THE CHAIRMAN: It wouldn't
2 be appropriate to question you.

3 MRS. MAILLOUX: No, Dr.
4 Spellman will be back in town on Monday. He is at
5 the disposal of the Commission. He would be most
6 happy to meet with you. Since this report was written,
7 he has been in India this past January and February.
8 He has further pertinent information that he feels
9 the Commission would benefit by hearing and he would
10 be most happy to meet with the Commission privately
11 or to submit further recommendations.

12 Thank you very much.

13 THE CHAIRMAN: Thank you very
14 much.

15 Does anyone care to make
16 any comments upon this submission?

17 I guess you made a sufficiently
18 clear comment.

19 I call then on Miss Sheila
20 Dillon.

21 MISS DILLON: Mr. Chairman
22 and Members of the Commission, I apologize but I don't
23 have a copy of my brief, however, I wasn't aware that
24 one was required.

25 First of all I think I
26 should give some of my background which I think
27 qualifies me to give this report. Since September
28 of 1969 I have been the full time organizer of the
29 Young Christian Student Movement and I work with
30 various groups of high school students in south-western

1 Ontario. With these students we have conducted a survey
2 to discover the needs of students, and we cover the
3 areas of home, school, leisure and religion, and
4 community life. I am also involved in sponsoring a
5 fair number of drug nights in a six county area.

6 The main reason for giving
7 this brief is to try and give a picture of young people
8 today and the role that drugs play. However, first of
9 all I would like to speak about the reasons for the
10 existence of drug use, the causes. Please keep in mind
11 it is centered around the high school student, the
12 white middle class kid.

13 In order to talk about causes,
14 we must examine the situation of the young person today.
15 What is happening to him, what forces are acting upon
16 him. It appears that young people today have just about
17 everything desirable, dances, shows, roller skating or
18 even hanging around drive-in restaurants. But to them
19 this gets to be a drag. Mundane. They want something
20 new and something exciting. Some leave home and travel.
21 Some turn to drugs. I truly believe we can draw a
22 parallel here between underage drinking and smoking
23 marijuana. Just as students used to think it was
24 really cool to get drunk, students today get their kicks
25 smoking grass. The popular tea festival is another sign
26 of dissatisfaction, the frustration and the search for
27 a new experience. It is the coming together of thousands
28 of young people to share opinions, aspirations, establish
29 some type of community, to grow and experience new
30 things together.

The educational system is another area that must be examined because a teenager spends approximately one-fourth of his day at school. I have a report on the school life and its linkage with drugs. This report was written by Greg (Burke). He is a first year University student and organizer of the Hassle Forum which is a committee of students from area high schools who are examining student dissatisfaction in the high school. And when I give this report please keep in mind that the educational system is a reflection of our society, so what I am saying about the system, I am also saying about what happens outside of it. And Greg's report is as follows: The motivating force in our schools today is not the desire to gain knowledge, not the yearning to learn about life, but rather fear. This fear begins the day the five-year old child walks into the kindergarten class for the first time. This fear however, is natural and expected, for it is frightening to enter a new and unknown environment. But instead of being alleviated, this fear is considerably increased. The child becomes afraid to say what he thinks, to act the way he would normally act. He fears the stigma of failure on examination of everyday work. He knows that any misunderstanding of corrections and material will lead to reprimands by the teacher. To the emotionally insecure child, and what child in grade school is not insecure, this fear forms the basis of his every action. Every move he makes is calculated to please the teacher, the agent of the fear. This fear is reinforced

1 through the high school years. It is not my desire
2 here to go into the reasons behind this employment of
3 fear as a motivater although I am certain that in many
4 cases it is inadequate. Let us examine some of the
5 effects of such a policy. One of the most serious
6 consequences of the use of fear to promote learning,
7 is a warped sense of values. Success becomes the
8 ability to live through fearful situations without
9 suffering the consequences. The "good student" is
10 the one who does and says what is required by the
11 teacher. The search for one's own personal truth
12 is mutilated into the search for the teacher's truth.
13 The school environment then is one of fear. But this
14 fear does not stop here. The belief of what constitutes
15 "success" is carried on into the home. Parents
16 responding to the notion that success for their
17 children means doing well in school, pleasing the
18 teacher, demand that their children do well. Thus,
19 in their home students fear hath discipline from their
20 parents and being censored by them. The result is
21 that the student spend most of his time in the home
22 and in school in an environment of fear, always
23 pressured for reaching an unreachable goal--success.
24 threatening constantly. Does it come as any surprise
25 then that he looks to drugs for an escape from this
26 fear, for a feeling of freedom and exhilaration and
27 rejection of the norms of society that place him in
28 such a frightening environment? A drug trip serves
29 a dual purpose, it releases a student
30 from his life of fear by allowing him to

1 forget that it exists, while he loses himself in the
2 experience. It gives expression to what is usually
3 a constant dissatisfaction with the stigma of success
4 and failure set by our society by disrespect for our
"sacred cow", civil law.
5 This whole problem can be examined from another point
6 of view with the emphasis presently on policing the
7 teacher. The true purpose of education, that is,
8 growth as a person, learning to be really alive is
9 tragically neglected. That is, as Marshal McLuhan would
10 say, "School interrupts one's education." Students
11 then are forced to search elsewhere for their identity
12 without the proper guidance, the kind of guidance that
13 should and could be provided in the high schools of our
14 nation. This search is indeed a difficult task. The
15 first step in such a search is usually a projection of
16 the norms of society that have neglected this present
17 need for identity. Where these norms are of no value,
18 this rejection is good. However, value standards are
19 often disregarded with the invaluable. The result is
20 the obvious preoccupation of the young with such things
21 as vandalism, speeding, excessive drinking and the use
22 of drugs, and the search for identity and rejection of
23 society. Regardless of how we look at this situation,
24 the conclusion is an obvious one. Our educational
25 system is simply not playing a constructive role in our
26 society today and it must be reformed. I truly believe
27 that young people today want to be given a chance to
28 build something. They are searching for an identity
29 and the use of drugs is one method of search. For us
30 to say "Don't do drugs, drugs are nasty," and, "no, no"

1 without offering them any other means of discovery is
2 absolutely assanine. I believe we are all convinced
3 that something must be done and we are willing to
4 give them both time and money, but we must watch how
5 we spend our money. Many of the things being done
6 today are an absolute waste of time. For example, the
7 drug film mentioned already, produced by the Windsor
8 Police cost \$30,000.00. A bit ridiculous when we think
9 of all the films available now, and that money could
10 have been spent helping young people establish drop-in
11 centres in the Windsor area, places that would give
12 them an outlet for their searching. Also, if we are
13 so concerned about answering the needs of youth, getting
14 the pulse of the situation, the Government should set
15 up a Department of Youth, with youth as representatives
16 for they are the ones most in touch with the situation,
17 most aware of the needs of other young people. In order
18 to really set up something, the young people need you,
19 the people in power on their side. We must show them
20 that we have the confidence, faith in their judgment,
21 we must listen to them, give them our time and our
22 support. We must give them the opportunity to discover,
23 to grow and to become fulfilled persons.

24 That's it.

25 THE CHAIRMAN: Thank you.

26 Miss Dillon, would you mind
27 remaining for questions?

28 MR. CAMPBELL: In the statement
29 that you quoted, certain purposes of education were
30 cited, and they were cited in a way that would imply

1 that they were exclusive. There was very heavy
2 emphasis on education for personal growth, for the
3 development of the individual personality. And certainly
4 I wouldn't for a moment deny this. But surely there
5 are other purposes of education, a major purpose of
6 education at the University level is to surely learn
7 to withstand the rigorous and tight discipline, to
8 function with high levels of accuracy in a tight
9 structure, to be able to withstand boredom, to take
10 on extremely difficult tasks and carry them through for
11 very long periods. There is a scientific conclusion,
12 to develop very high levels of technical expertise.
13 It would seem to me that your statement on the purposes
14 of education overlooked --- for instance in my own
15 field of sociology, the person with any competence at
16 all as a Professor in Sociology has to spend a great
17 deal of time in the study of mathematics and statistics.
18 This is a highly disciplined activity. It is not a
19 soft activity, it is an activity that may involve great
20 amounts of boredom, of hard work, of doing things that
21 a person doesn't enjoy doing at all. And surely along
22 the way there are people who are going to have to be
23 failed, they are going to have to be told they are no
24 damned good, they are not good enough to qualify. Isn't
25 there a point, perhaps, in growing up, where a child should
26 learn to fail, that he is not good enough, that he
27 hasn't worked hard enough, he hasn't been disciplined
28 enough because he isn't good enough to function, and we
29 can't in a society allow him the privilege of functioning
30 in a way that it can effect other people's lives?

1 Medicine, dentistry the pilots of airlines, things like
2 this, these people must be damned good.

3 MISS DILLON: Yes, and he
4 has failed in one area so perhaps he should move on to
5 another. And you talk about rigorous training and long
6 periods of hardship etc., etc., and I look at the
7 University of Windsor and I question how many students
8 are going through that. I think just about --- oh,
9 the major experience they are experiencing is boredom,
10 and because they just don't care about going there.
11 I think that if they were truly interested in a field,
12 like you are interested in sociology, or, you know,
13 something like that, that they would be willing to
14 learn the mathematics and the other things that they
15 had to go through to qualify.

16 MR. CAMPBELL: Perhaps they
17 shouldn't be in University.

18 MISS DILLON: That's right.

19 MR. CAMPBELL: Perhaps they
20 should go somewhere else.

21 MISS DILLON: Perhaps we
22 should change our school system at the bottom, so that
23 when they get to University they will care enough, they
24 will want to develop their mind, not only because they
25 are at school, but because they want to grow as persons.
26 When I talk about growing, I am talking about a personal
27 thing, but I am also talking about something intellectual
28 and just because you stop going to school doesn't mean
29 you stop learning. Now I don't think you mean that at
30 all.

1 MR. CAMPBELL: Not at all.

2 No, I am concerned with a number of people and I have
3 seen quite a few working in prisons and I have seen them
4 certainly in University, people who I think were misled
5 by a soft school system; they hadn't met failure, they
6 hadn't met very difficult tasks, and suddenly they
7 found failure and they found very difficult tasks and
8 the experiences they have had and that I think was a
9 rather soft environment where people didn't fail perhaps
10 enough, didn't prepare them to meet the fact that
11 sometimes they just didn't measure up, and they had
12 to be told, "Look, that's not good enough, you failed."
13 Now, sure, perhaps that does inject fear, in fact I
14 am sure it does, but they are concerned, and I am
15 wondering how you can avoid that consolation if we are
16 to maintain certain necessary standards.

17 THE CHAIRMAN: Gentleman at
18 the microphone?

19 THE PUBLIC: I don't know
20 exactly where to start with that, because most of it
21 to my opinion is pure unalderated crap, unless I know
22 precisely what you are talking about.

23 The first thing I have to ask
24 and I mean no disrespect, but I have to know what you
25 mean by discipline. Like, what do you mean by
26 discipline, because there are two distinct sets of
27 discipline, you know, in general terms. There is what
28 I impose upon myself as discipline and then what you
29 impose upon me as discipline.

30 MR. CAMPBELL: I think I was

1 thinking mainly of the disciplines imposed by the
2 subject of problem.

3 THE PUBLIC: But to deal with
4 that --- do you want me to deal with it or do I want to
5 deal with it? That is the question. The question
6 comes down then that if this problem is to be dealt
7 with and I want to deal with it, then there is a number
8 of things that I have to do and I want to get these
9 things done, then I have to recognize that. The fact
10 that you recognize it means nothing.

11 MR. CAMPBELL: I may very well
12 want you examined by a third person to test your
13 competence in achieving certain results of the method.

14 THE PUBLIC: There is no
15 doubt that my competence has to be examined, but we want
16 to go down a bit further than that. In talking about
17 schools in general, do they ever want to attempt to
18 find out what I am interested in? Things are changing
19 in the grade schools I will admit, though it is nothing
20 short of a joke considering the number of schools that
21 are changing, But nobody ever came to me and said, "look
22 is this what you want to do?" Now I just got my B.A. and
23 I took twenty-four subjects and I don't know, maybe
24 four or five of the profs ever bothered to ask me what
25 I wanted to do, and now I am supposed to be educated,
26 you know I've got these twenty-four things that I did.
27 But that does not necessarily make me educated and it
28 doesn't mean because I'm competent in those particular
29 areas that I want to be competent. The fact of the
30 matter is it doesn't mean anything to me. There are

1 eleven guys there with Doctorates and Ph.D.'s in
2 physics who are not going to get jobs. And the
3 question is this, that they are sitting there waiting
4 for somebody else to offer them a job. I would think
5 that by the time someone has a Doctorate and can do
6 nothing on his own, then what the hell is the use?
7 And what I'm saying is this, that I think it would be
8 just about cool if I had some background and I think
9 everybody has something to offer, and what is going to
10 happen to me, and what makes me sick and makes a lot
11 of kids sick, is that just this summer there are no
12 jobs, I've got no bread, it costs me two bucks to go to
13 a show, I can hitchhike to Toronto I've got to take
14 a bus, that costs me money. You know. And what I'm
15 telling you is that those places don't ever try to
16 establish creativity. So why in God's name don't I go
17 and do something else? What difference does it make
18 if I go and drop out?

19 MR. CAMPBELL: Well, you have
20 raised many issues. The first issue you raised is that
21 the individual should be free as he wishes, in University
22 or in high school. I don't know^{what} University, and I
23 probably would not know the details of the programme
24 or what problem it was to you. Certainly in the
25 University I have been involved with, there were
26 relatively few required subjects. There was an enormous
27 range of options to students, and he was free to select
28 from a number, a great number of courses and he did
29 not have to attend that University if he did not like
30 the set up.

1 THE PUBLIC: How many universities
2 do you know of where you actually walk in and say to
3 somebody who is competent to teach you that I might
4 like to take this, and the two of you sit down and
5 discuss that and you do it. Do you know of any?

6 MR. CAMPBELL: Yes.

7 THE PUBLIC: How many?

8 MR. CAMPBELL: Any that I have been
9 associated with.

10 THE PUBLIC: No, are you going to
11 tell me that the universities don't put out a pre-
12 planned calendar?

13 MR. CAMPBELL: Of course they
14 do.

15 THE PUBLIC: And if I disagree
16 with some of the things, I really have no choice, and
17 you say, go somewhere else.

18 MR. CAMPBELL: You have two
19 options. The university I am associated with now
20 there are a great many students representative in
21 forming the curriculum of the university.

22 THE PUBLIC: So that's nothing.

23 MR. CAMPBELL: That is one way.

24 THE PUBLIC: What you don't seem
25 to realize is that you have this big structure, you
26 to this big committee on Saturday...
27 portion inaudible...

28 THE CHAIRMAN: What really
29 makes it work?
30

THE PUBLIC: What really makes it work is that so many examples of Universities that were built on structures and people came together and were considered like really freaky places in the thirties, a place like Sarah Lawrence, Bennington, Goddard, which maybe ^{you} heard of because they have damned big names, and what we are trying to say is that you go back and do a little bit of reading on something so trivial as Dans Packard and see from the studies he has done on factories and talk about responsibility, you are not told to do this and this, that those people actually performed better. Those people know what they are doing. Now you don't get involved through the University. By the time you get to University **it is too late**. When you think about the fact that when you walk into the classroom, you walk in and at--I walked in at 9:00 o'clock in the morning four years ago and I sat down and talked with a couple of guys I knew, and all of a sudden this guy walked in the front and everyone was very quiet. We all really shut up because there he was. I didn't remember much of my trig or algebra or history and I didn't know any Phil at all and I spent about fourteen years doing this, and what I really had learned was that when the guy walked in the front of the room I shut up. That is what I really learned. That is what everybody learns by the time he gets to University. Man, you can't put me through thirteen or fourteen years of school and say so long as you are under the authoritarian structure that you are going to come out to be a creative

1 individual. That is just silly. So what we have to
2 go back into now is --- well that is the motivation
3 behind things like drugs.

4 THE CHAIRMAN: But there is
5 a thing called --- there is no question that you have
6 got to have your creative potentials stimulated, or
7 given as much scope for development as possible, but
8 there is a thing called discipline. I am not speaking
9 about discipline, personal discipline, conduct, I am
10 speaking about discipline as a branch of learning.
11 Professional discipline. You are not obliged to choose,
12 all right.

13 THE PUBLIC: That is true.

14 THE CHAIRMAN: Supposing you
15 choose --- let me speak about my own.

16 THE PUBLIC: Could I just
17 continue for a moment because I made a mistake when I
18 started. I want to make a distinction between education
19 and training.

20 THE CHAIRMAN: Well all right,
21 now you have me on the defensive, because you see we
22 concern education an art in law. Be that as it may.

23 THE PUBLIC: I disagree. I
24 am a drop-out from Osgoode.

25 THE CHAIRMAN: When did you
26 drop out?

27 THE PUBLIC: I dropped out
28 in November, and I disagree with what you have to say.
29 proposed making the courses longer to give us a chance
30 to internalize it. I didn't want to be a walking

1 textbook. I was being dehumanized, I complained to my
2 fellow students and they said, "Forget it" we want the
3 money." They didn't care about human beings, and you
4 can ---

5 THE CHAIRMAN: I certainly
6 walked blindly into that one. You know, my first
7 instinct was I was going to talk about the medical
8 profession. You live and learn. But anyway, we have
9 to kind of detract here, but let us talk of this
10 ideal professional school somewhere in the world where
11 the community gets together, the community as a whole
12 and says what is it, what is the core that is required
13 here as the ongoing body of professional learning which
14 can give some basis for professional competence, in
15 its most imaginative scope, okay? Professional com-
16 petence designed in the most imaginative and comprehen-
17 sive way. Now, at some point you have got to expect
18 that there is somebody, some corpus of education which
19 is essential and you can still leave a body of choice,
20 but you can't get away from that.

21 THE PUBLIC: I don't think
22 that I will try to deny that. If I go to a dentist
23 to pull out my tooth, and he pulls off my left ear,
24 I am going to worry about him. The thing is this, I
25 had a weird experience on the weekend. This guy picked
26 us up when we were hitchhiking on the weekend, he was a
27 math teacher and I thought it was really strange, and
28 we started talking and it was really interesting, and
29 he had been teaching mathematics by discussion for
30 the last fifteen years. If he can teach mathematics

1 by discussion, you can teach anything by discussion.
2 What I'm trying to point out is that this idea you are
3 talking about, it is not even anywhere near. It goes
4 back to what people say, that I can sit here and talk
5 to you and I've done a lot of talking and I'm not going
6 anywhere. It doesn't really matter very much if there
7 were 10,000 of us out of 15,000 who said yes, we would
8 like to do this particular thing. We are still the
9 minority because we hold down no positions of power and
10 people say, wait until you get your Doctorate and you
11 will get to be President of the University. When you
12 are sixteen by that time I won't work down there with the
13 twenty year olds, anyway. That is some kind of joke.
14 With the advance in education, you have to recognize ---
15 you have to tell them what is going on, let them have
16 some action.

17 DR. LEHMANN: Have you ever
18 considered one very tedious, but a very realistic
19 argument and that is, that it would take a great many
20 more people, teachers of a very high caliber, higher
21 than are available now, to do this sort of teaching?
22 For instance in medicine, it is well recognized ^{the best system would be} if every
23 student would have one tutor. But it is difficult enough
24 to find enough teachers as it is for about a class of
25 about one hundred and to get a hundred times more
26 teachers of much higher caliber, is just realistically
27 impossible.

28 THE PUBLIC: This is another
29 thing, you know, we have the calendar at the University
30 of Windsor and it says all ratios 1 to 11. There's guys

1 down there that teach one class to graduates two hours
2 a week and rush off and do research---portion inaudible
3 ---where they have free spice in a certain clinic and
4 they are getting paid for these sort of things and that
5 is crap. But that is not even so much a social porblem,
6 more of an economic problem that people make up. There
7 is all kinds of resources in Canada, but if we would
8 just manipulate it.

9 DR. LEHMANN: With all the money
10 in the world, if you gave me a billion dollars, I
11 could not fill the need for teachers in medical schools
12 in Canada which would be required to have this kind of
13 ideal, and I agree certainly the best kind of education,
14 it would just not be possible.

15 THE PUBLIC: Just like, for
16 example, the law profession is one you can use, you
17 can use the medical profession or you can use the law
18 profession and there are others too. That emotional
19 transect an artificial monopolies by bouncing people
20 out of school because they don't drink with the right
21 crowd, and that's a fact. We don't recognize that
22 everywhere but those are very realistic things.

23 DR. LEHMANN: That doesn't require
24 an excuse or justification. But that isn't what we
25 were talking about. If it is agreed that the present
26 system of education is an inferior one, one would also have
27 to admit that if you really look into it--if you were in
28 charge of organizing another one, you just couldn't do it.
29 do you would either have to have the choice either no
30 education, or the next best, which is not a very good one

1 which we have now. Now what would you choose?

2 THE PUBLIC: That is not the
3 choice at all.

4 DR. LEHMANN: Perhaps a little
5 better than now.

6 THE PUBLIC: Not much better
7 than now because there are obvious examples where that
8 is done and I am talking about schools like Sarah
9 Lawrence, Bennington, Goddard or others that are much
10 better.

11 DR. LEHMANN: You couldn't
12 do it now. There just aren't enough teachers.

13 THE PUBLIC: What about kids
14 that don't have jobs?

15 THE PUBLIC: There are 4,000
16 teachers now at the secondary school level that don't
17 even have jobs and there is a good beginner.

18 MR. CAMPBELL: I want to talk
19 about those schools you mentioned. I know a little
20 about Bennington, Sarah Lawrence and Goddard. Now
21 Goddard is slightly different than Bennington and Sarah
22 Lawrence. Bennington and Sarah Lawrence are rather
23 wealthy schools and that whole cluster of small New
24 England schools and some out West are extremely well
25 paid. They have predominance, they have heavy support
26 from the alumni, and so on. Now certainly in the
27 Province of Quebec, to move from the University that
28 I am involved with from 20 to 1 or worse ratio, would
29 involve a very, very serious increase in taxation, and
30 it looks very much at the moment as though the Canadian

1 public at large say that they are damned if they are
2 going to be taxed any more for the universities and I
3 think they have a right at some point to set the level
4 of taxation they will withstand to support the University.
5 I think the thing is probably cruel on behalf of the
6 University of Montreal because they have problems. The
7 people are just saying there is a limit to where you
8 will be taxed to support universities, and move in many
9 of the directions, and I agree with you, we simply have
10 not got the resources, or the people feel they haven't
11 and it is the people who make those decisions, democratic.

12 THE PUBLIC: I don't feel you are
13 speaking on topic at all.

14 THE CHAIRMAN: On what? It is
15 very basic.

16 THE PUBLIC: I will continue on a
17 little further. What bothers me, is when people start
18 screaming about how much taxes they are paying, they
19 don't start screaming when you take off the top ten bucks.
20 they start screaming when you are getting down to the
21 point when you are really cutting into the basic necessities
22 because I think you could just see the level of taxation
23 in this country. People are crying out and bitterly
24 complaining where they just get to the point where
25 they have been, but they haven't got to the point
26 where they have burned down your Parliament Buildings
27 yet. What I am saying, you have to cut into
28 people's basics, now again this is where I am afraid,
29 how much wheat have we dumped into the ocean this
30 year? Why do we pay a guy like E. P. Taylor

1 something like three hundred thousand bucks to raise
2 race horses? Why do the jerks down at the University
3 of Windsor lay a sidewalk and lay the same damn thing
4 and put a park up and charge me for it and charge you
5 for it and nobody even knows about it? Like that's
6 money and that's food, you know. And why do we sit
7 here and we talk about that City Auto Park that we
8 had that legislative emergency on, we shouldn't be
9 turning out 73,000 cars. You know, we could do much
10 like some sensible nation like Sweden that seems to
11 have something to look forward to. Not perfect, there
12 is no perfection in my mind. Why do we do those kind
13 of stupid things?

14 MISS DILLON: Better question
15 yet, why do people question us doing those stupid
16 things?

17 THE PUBLIC: Well, it beats
18 me baby, I don't know. You know? I'll admit I am a
19 cynic. I think men are basically so stupid and
20 living ---

21 THE CHAIRMAN: That is the
22 basic issue. I think that is really what interests me.
23 What do you propose to do about it? I mean dropping out
24 and I'm not making any allusion toward dropping out of
25 a particular programme, a person may be perfectly
26 justified in dropping out from any particular study
27 or vocation if it isn't what they want. I don't mean
28 that, but just generally disengaging with a kind of
29 despair or hopelessness I / ^{mean} the criticism you are making, is
30 not altogether without some echo in our own memory, you

1 know. I mean we had our radicalism, it was very hard
2 hitting. And I don't say we have any particular virtue
3 from this generation the way we responded to it, but
4 my point is, are you going to stay in and try to
5 influence the development of it? It seems that we
6 have got to work with the institutions, we have got to
7 work with a complex society, or are you going to just
8 say to hell with it and walk away from it, and
9 occasionally sound off, you know, and give us the
10 gears critically and walk away? I mean this is the
11 issue. It is one of the issues.

12 THE PUBLIC: Well, you know,
13 this of course is the dichotomy, what are you going to
14 do, are you going to live today and say now they are
15 going to blow us up in a few days anyway, something
16 like that, or are you going to get in there and, you
17 know, try and make the system work. But what is so
18 ridiculous is ---

19 THE CHAIRMAN: Improve it.

20 THE PUBLIC: Okay, improve
21 it, but let's just consider --- let's consider for a
22 moment the number of resources that the Government has
23 just in manpower resources. And let's consider the
24 number of people who are capable of contributing to
25 that Government and the amount of dollars that they
26 have. Now do you honestly think that that Government
27 uses every bit of knowledge that they have, properly? I
28 shouldn't use the word properly. What bothers me just
29 in the area of the Universities, and I am a University
30 student, I know a little bit of what goes on there. We

up
1 have a University and we keep putting/buildings, and
2 the whole rat race, and we are all going to have home
3 bases and we will be ready to ride our Hondas from place
4 to place anywhere from University Avenue to Tecumseh
5 with just buildings, and we know we are going to have
6 all kinds of celluloid things, they are going to move
7 the entrance to the bridge which is going to cost a
8 fortune and what they could do is they could build a
9 second campus out here and it wouldn't cost them any
10 more, probably cost them less. You know very well
11 that the University of 3,000 people works better than
12 the projected 20,000 thing that you are going to put
13 up here, but we don't bother to do it.

14 THE CHAIRMAN: People are
15 doing these things out of perversity? Is it possible
16 we are all hanging around here in the urban bind because
17 we just don't know how to disengage in an orderly and
18 economically feasible way? I mean, why to you think
19 it is perversity? It is not a sinister conspiracy. We
20 are baffled by how to cope with it. There is nothing
21 holding you in Windsor. Why don't you go fifty miles
22 out and hire/^{out to}someone as a farm labourer? Because
23 employment opportunities are concentrated and industry
24 has required itself economically to concentrate and so
25 on. I mean, we are all caught up in this.

26 THE PUBLIC: I don't know
27 exactly how that deals with what I said.

28 THE CHAIRMAN; Maybe it was
29 irrelevant, I don't know.

30 THE PUBLIC: I guess it has

1 been a long day and maybe --- been a long year for you
2 people.

3 THE CHAIRMAN: I beg your
4 pardon?

5 THE PUBLIC: Maybe it has
6 been a long year for your people, I don't know.

7 MR. STEIN: Let me ask you
8 a question because if I understood the Chairman, what
9 he was saying to you, and it was perhaps a very
10 personal kind of a question, as I understood it.
11 done this a long time -- presume to know what one of
12 my colleagues meant by a question. I will ask you my
13 question. What do you as a guy who has had a lot of
14 concern and presumably from some of the things that
15 you have just said to us, fairly concise analysis
16 of certain things that are not good in your estimation,
17 what do you see as immediate alternatives available to
18 you at this point in your life? Is this it, coming to
19 the Commission and telling us this kind of thing and
20 backing up, or is there --- well, I don't answer the
21 question, what do you see as alternatives?

22 THE PUBLIC: For me personally?

23 MR. STEIN: Yes.

24 THE PUBLIC: That is a bad
25 thing to ask me because I have had the same problem
26 trying to answer that, go back to school and back
27 to the fact that I am working now or something else,
28 or maybe just take off and travel for a while and do
29 a little experiencing things on my own, maybe getting
30 involved with a political party. I have had a chance

1 to get involved with the N.D.P. if I wanted. Trying to
2 find --- maybe trying to set up something on my own,
3 some type of a movement but I don't know where you start
4 with that exactly because somewhere along the line you
5 might have a little success, you know, and you'll get very
6 frustrated.

7 DR. LEHMANN: Do you?

8 THE PUBLIC: On occasion, yes.

9 DR. LEHMANN: Well, we have
10 often been told that that is not what one should be up
11 to. You indulge in it from time to time, success?

12 THE PUBLIC: Oh, success. We
13 are talking about two different things now, eh? I am
14 not really interested in ---

15 DR. LEHMANN: In making money,
16 but you want success?

17 THE CHAIRMAN: You want a
18 sense of achievement?

19 THE PUBLIC: Oh, yes. Yes,
20 that is true. We want people to listen and act. I really
21 can't answer your question as fully as I would like to
22 because I am afraid something is really on my mind now ---

23 MR. STEIN: If I may, and if
24 I can tell you what you are trying to say, you haven't
25 decided yet to walk away. You may, but you haven't made
26 that decision because you have just thrown out

27 what to me were a range of things you are still trying
28 to figure out which one to choose.

29 THE PUBLIC: I think most of
30 the people that are here, you know, with the group I know

1 are probably in the same situation and they are actually
2 trying to figure out what to do, but I think the real
3 thing is that we cannot, and I emphasize this, in
4 every respect that I can, that it is totally impossible
5 for the people I appear with today and for myself,
6 absolutely impossible and no way can it be done, that
7 I will ever be able to move right back inside your
8 system again. I will never ever be able to do that,
9 I could just never do it.

10 One last think and I will
11 pack up here. For you people, and I hope you recognize
12 that when you make your recommendations that you are
13 going to make/to ^{them} a Parliament that is going to be
14 opposed to the thing probably, and it doesn't make
15 any difference what you do and it doesn't make any
16 difference what they do, you can never ever stop it.
17 It is now too late. There is nothing you can do, that
18 you gentlemen here can listen and I hope you find this
19 an educational experience, that you are really learning
20 and trying to understand because that's all you can
21 accomplish. And if you don't come out with things like
22 positive legislation in the area of marijuana, then
23 you are done for. You have done nothing. I am serious
24 about that. There is nothing you or anyone else can
25 do, just nothing. (applause)

26 THE PUBLIC: It seems to me
27 that there were quite a few issues raised there on all
28 sides, and I would like to grab hold of one. First
29 of all we were talking about discipline in terms of
30 the professions and what is called for in terms of

1 setting up some sort of criterion, let's say, as to
2 the admission to professions. As a psychologist I find
3 that probably the most irrelevant total approach is
4 taking place inside of the Universities in terms of
5 meaningful education and psychology. I feel very
6 strongly that there is not nearly enough work being
7 done in the community at large and that there is a
8 great area for the training of both under-graduates
9 and graduates in the community, and I think that this
10 is a direct application of professional responsibility.
11 I think that we are touching on the same thing when we
12 talk about legal reform on the part of the legal
13 profession. We are well aware for many years of the
14 inequities of the legal system and yet the one profession
15 that stands in the position to do the most influence,
16 seems to do the least. The medical profession seems to
17 me to have created a large part of the drug problem that
18 we have today by virtue of the way they have kind of
19 gone blindly with, in some cases, a direct lack of
20 professional responsibility into a relatively unknown
21 area. I think these are some of the kinds of answers
22 to the questions that these people are raising. But I
23 guess I am somewhere in the middle between how they see
24 you and maybe how you see them. I certainly think that
25 I don't think the system is lost, but I think that the
26 speed with which we have changed it technologically
27 now has to be matched with the corresponding speed
28 socially and I don't see any reason except attitudes
29 which is, you know, a rather major one, but I think
30 people have got to start to come down to recognize that

1 without this kind of double opportunity if you like ---
2 I am not denying the necessity for professional
3 discipline. On the other hand, one could seriously
4 question the kinds of professional discipline
5 being perpetuated and whether or not it is creating
6 the kind of elitist system that has been talked about.
7 I think these are some really important issues that
8 this drug question has raised, and it is unfortunate
9 in a way from our point of view working in the drug
10 field, that most of what goes on gets glossed over by
11 the existence of the drug problem. It is unfortunate
12 that marijuana is the catalyst for this kind of a
13 social examination. But it seems to me that in the
14 long run the whole meaning of the thing may be lost.

15 THE CHAIRMAN: Thank you.

16 THE PUBLIC: I am really
17 grateful for the drug scene because we can't just
18 throw back the money and say that we can't afford to
19 change our educational system, or we can't afford to
20 change our society. When things were comfortable and
21 people weren't all excited about the drug scene, it
22 was rather comfortable, but now they are getting
23 excited because they are so worried about what is
24 happening to young people and it is forcing us to
25 look at what ^{is} causing, and unless we get scared
26 about the drug scene, we don't get furious enough
27 about the personal harm that is going on in our
28 country through our schools, through our whole
29 economic set up. So maybe now we will pay some
30 attention to what is really basic to this supposed

1 drug scene.

2 THE CHAIRMAN: Thank you.

3 MISS DILLON: I just have
4 one point to make. You have said something about
5 discipline and taking on a job as a profession person
6 and that you had to have a certain type of discipline.
7 Well, for a long time I have been wondering whether or
8 not I want to become a professional person in the world
9 today. Whether I want to have to fit into my little
10 nook. I want to do something about what is happening
11 but I don't know whether I like the means which are
12 offered to me right now to do it.

13 THE CHAIRMAN: Is Mr. Allan
14 Golden here?

15 Would you like to make your
16 submission?

17 MR. GOLDEN: I would like to
18 begin by saying that this panel, this Drug Commission
19 is not exactly as (euphonious) as say a panel would be
20 composed of Jimi Hendrix and John Lennon and Allan
21 Ginsbergh, but then a panel composed of Jimi Hendrix
22 and John Lennon and Allan Ginsbergh would not have
23 very much leverage to influence the public. If you
24 look at this in a way of balancing the potential that
25 this Commission has to make its views felt by the public
26 and also the open minded approach which they are taking,
27 I think we have a lot to be grateful for. All you have
28 to do is be familiar with the style of Government
29 hearings in the United States conducted in an
30 up-tight manner, inquisitorial, indignant and compare it

1 with this hearing and I think you can appreciate that
2 this Commission is fair and open minded and a tolerant
3 body, and I would like to commend them on the approach
4 they have taken.

5 This is to bear witness that
6 LSD, if used right, can produce fundamental religious
7 experiences which transcendent the individual mind and,
8 at the peak, direct immersion in the holy oneness of all
9 being, that goes variously by the names "oceanic
10 consciousness", "cosmic consciousness", "transcendental
11 consciousness", "the Godhead", nirvana, satori, the
12 tao, etc.

13 There is such a thing as a
14 mystical experience. It is as old as is man's mind.
15 Descriptions of it exist from all times, from all areas
16 of the world. It is described in similar terms by many
17 independent visionaries throughout time, who had no
18 contact with each other's traditions or records.
19 Similar geographic records come from East Asian cultures,
20 from South American and African cultures, from the
21 Hebrew Kabbalists, Catholic mystics like Jacob Boehme,
22 from the psychedelic trippers. LSD psychedelic art
23 bears great resemblance to ancient Hindu cosmic art,
24 Aztec art, Kabbalistic art, etc. For this you can see
25 Masters and Houston, Psychedelic Art. Psychedelic
26 music, in its flowing molten rhythm within rhythm style,
27 resembles nothing so much as the rhythm in the East,
28 although only in retrospect. Often the music has been
29 produced with spontaneous results and some would say,
30 hey, that is very much like an Indian rock. Ancient

1 mystical texts which previously seemed obscure, vague,
2 read clearly and easily in the light of one's own
3 LSD experience.

4 I will not attempt here to
5 document all these experiences and give content
6 comparisons. This has all been done in detailed
7 volumes. I can refer you to "Mysticism," Evelyn Underhill,
8 which catalogues transcendental consciousness as
9 described by a wide variety of seers, poets, holy men.
10 Read also Bucke's book, "Cosmic Consciousness." The
11 bookshelves of any store or library, under Eastern
12 philosophy, bulge with such descriptions. Pick up
13 any survey book of poetry and you will likely find
14 somewhere a similar description. Pick up any book,
15 look through it and some poet somewhere, Blake or
16 Lord Byron will be describing transcetdental experience.
17 Then compare these experiences with the drug experience
18 described in Masters and Houston's, "The Varieties of
19 Psychedelic Experience," and "The Ecstatic Voyage" by
20 Ralph Metzner, or similar volumes.

21 Any open minded person who
22 reads through volumes of testimonials must conclude
23 there is at least a possibility,
24 that powerful psychedelic drugs like LSD do produce
25 bona fide mystical experiences. I do not expect any
26 rational observer to be convinced by these reports.
27 The only evidence powerful and convincing enough to turn
28 agnostics into gnostics, turn skeptics into convinced
29 spiritual persons, is the real immediate total power
30 of the experience itself. It is as foolish for a

person inexperienced in these realms to challenge the validity of these transcendental states, as it is to fully embrace the stated truths of these states without experiencing them. The only way to really find out is to try it on oneself.

There is one scientific attempt with which I am familiar to evaluate the validity of such experiences by comparing their content with descriptions of the mystical experience throughout history. This was the Good Friday experiment of Walter Pahnke. A group of volunteer inexperienced divinity students assembled in Boston chapel on Good Friday several years ago. They were divided into groups of four, and told they were given doses of psilocybin and were to report on their experiences. In each group of four, two were given psilocybin, a psychedelic resembling LSD, which is derived from the magic mushrooms of the Mexican Indians, and two were given a placebo, a drug that produced some of the superficial somatic effects that you might expect without the deeper expanded consciousness effects. Descriptions of their experiences were then subjected to a content analysis, matched with a list of characteristics of the classic mystical experience as abstracted from the reports of visionaries of the past. The experiment was triple-blind in that neither the supervisors of the the subjects nor the graders of the content knew until afterward which had been given the placebo and which the psilocybin

I do not have the exact figures

1 on the result. They can be obtained from Masters and
2 Houston's book, but the psilocybin subjects reported
3 profound spiritual experiences in high incidence, not
4 so the placebo subjects.

5 There have been several
6 other studies based on secular religious trait. I
7 won't bore you with the details. It can all be checked
8 through in Master and Houston's The Varieties of
9 Psychedelic Experience.

10 I recommend to you the Masters
11 and Houston's book especially for its skeptical
12 scientific approach, because through their research
13 they remain rational, skeptical, reporting factually
14 and honestly on their subjects, with no spiritual
15 commitment themselves and obviously limited experience,
16 throughsome experience with these chemicals. But their
17 findings speak for themselves. It might be their
18 misfortune that they are honest and open, but I am
19 overwhelmed by their findings. They had no other
20 recourse but to report what they found.

21 Timothy Leary's writings
22 reveal a much more profound, illuminated, detached
23 understanding of the psychedelic experience itself.
24 To any such spiritual writings I apply the acid test.
25 I read them while high on LSD. On LSD, all super-
26 fluties, all egotistical ploys, anything that isn't
27 real or direct doesn't make real or immediate sense to
28 you, either in yourself or others, shows up glaringly.
29 There are various writers whose depth and real
30 clarity and insight ring true to a psychedelic state.

1 Among them are the Chinese Taoist mystics Lao Tzu and
2 Chuang Tzu. But no writing I have encountered reflects
3 better and truer the expanded states than does Leary's.
4 I consider Leary to be the most illuminated person to
5 ever record his experiences. He has had over
6 600 of them. You see the tortured strivings
7 he went into trying to regain his state which
8 he tried to regain, and maybe ten years later he
9 would experience again, and in between he tries
10 to experience again and reproduce his experiences.

11 Of course, Leary has lost
12 all credibility in the scientific community,
13 because he talks about God and love and
14 believes in the goodness and holiness of the
15 LSD experience. The charge is that he
16 has lost his objectivity. Objectivity is
17 the ability to stand off, to stand apart.
18 This is necessary in the process of
19 observation, the approach has got to be
20 different. On an internal psychodynamic
21 level, objectivity is the wish to be apart,
22 safe, untouched by what is happening around
23 you and in you, shielded in sterile, clinical
24 security. There comes a point in the LSD
25 experiences when you have to let go of
26 this protective shell. Strong waves of
27 meaning are sweeping you out beyond
28 your safe scientific roles. You have
29 to at that point go with it,
30

1 give up, let yourself be carried away. This is the
2 art of letting go, the mystical surrender. If you
3 can do it, you experience existence on deeper, richer
4 levels. If you can't, then you pace the floor, smoke
5 cigarettes, run for comfort to some other person,
6 find some distraction, until the drug effect wears off
7 Then you denounce LSD and declare that LSD does
8 definitely not produce mystical experiences.

9 This is the position of some
10 psychiatrists who have set themselves up as strong
11 critics of the religious LSD people on the basis of
12 one or two negative experiences of their own, in which
13 they were unable to give up their psychiatric frame of
14 mind. Masters and Houston note, "It is characteristic
15 of those persons who have painful experiences with
16 psychedelic drugs that they attack the experience
17 with great vehemence."

18 This brings me to an important
19 point I would like to make. The Canadian public, it
20 seems, has come to rely on almost exclusively psychia-
21 trists as having the expert opinions on drugs. After
22 all, drugs involve the mind and psychiatrists are the
23 experts on the mind. I do not believe that we should
24 rely totally, or even largely, on the psychiatric
25 profession to rule on the legitimacy or value of
26 psychedelic drugs.

27 First, few psychiatrists have
28 taken LSD themselves. And, I'll repeat, there's no
29 way to understand the experience without undergoing it.
30 So it is impossible to conceive of what it could be like,

1 it just differs so fundamentally from anything within
2 the normal frame of experience.. The closest resemblance
3 is to the really good orgasm. But still, it is far,
4 far -- also, most psychiatrists, by virtue of their
5 training and inclination, tend to be specially unsuited
6 for the psychedelic experience. Much of psychiatry
7 seems to demand that all experience and consciousness be
8 verbalized, verbally, analytically representable. This
9 is the whole basis of psychotherapy. You talk about it.
10 But LSD requires you to go beyond verbal, analytical
11 awareness to experience on the level of body intuition.
12 Much of psychiatry's orientation is towards self-control,
13 to strengthen the personality, to get you in there as
14 an effective, positive, productive member of society.
15 Deep psychedelic experience demands that you leave the
16 personality behind, that you shed it like a snake shedding
17 its skin, and experience directly without the mediation
18 of ego controls. Later, you re-enter your personality,
19 hopefully improving it.

20 The fact is that the analytical
21 frameworks which most psychiatrists pick up in their
22 training, their view of the mental processes, is too
23 superficial and single-levelled to deal with the multi-
24 level, synchronic, energy wave bombardments of LSD.

25 I have heard one report of the
26 extensive Harvard psilocybin and LSD experiments done
27 with thousands of subjects from all walks of life. I
28 apologize that the short notice I had in preparing this
29 brief did not permit more detailed documentation. You
30 can check into it if interested. Anyway, the report I

1 have is that of all occupational groups subjected to
2 these experiences, including engineers, writers, artists,
3 physicists, truck drivers, convicts, and so on,
4 psychiatrists had the highest rate of panic reaction and
5 experiences which had to be terminated by tranquilizers.
6 An artist will be inclined to appreciate the experience
7 aesthetically, and go into it with curiosity and
8 openness, letting it take him where it will. Some
9 physicists have experienced deep insights into and
10 understanding of Einstein's theory of relativity, which
11 depicts reality as existing on many levels. A
12 hedonically oriented person, fun loving person, will
13 groove on the sensual flood and radiant body good-feeling,
14 and let himself be carried along. But to a psychiatrist,
15 most psychiatrists that I have heard speak, I have read,
16 the psychedelic flood is likely to come as a direct
17 threat to the system on which he has based his own
18 world-view, his whole livelihood. I mean he has been
19 subjected to analysis and he has got everything set and
20 straight, and knows exactly where it is at, and then all
21 these strange things start happening to him. It will
22 be alien and he may react with great fear and resistance.

23 I repeat, it is foolish to
24 rely on psychiatrists to pronounce on LSD and other
25 psychedelic drugs. On a psychodynamic level, they are
26 very much a special interest group. I'm sorry, I know
27 it would be nice to have a body of experts passing down
28 ex-cathedra pronouncements, especially in an area so
29 overwhelming in its scope and complexity. But it just
30 can't be done here. There are some exceptions. I will

1 mention two I know, Dr. Ronald Laing, an English
2 psychiatrist who describes his own LSD mystical voyage
3 in his book The Bird of Paradise which comes with
4 politics of experience, and Dr. Humphrey Osmond, a
5 cultured, sophisticated, open minded Englishman, who
6 did some research with Abram Hoffer in Canada. You
7 have probably hear from Dr. Hoffer, and he is now head
8 of the New Jersey Neuro-Psychiatric Institute in
9 Princeton.

10 Everybody has got to be his own
11 researcher with LSD and if a person does not feel strong
12 spiritual interest, or if he does not want to take
13 the risk, that's find. I'm not saying that everybody
14 should take LSD. But if a person is interested, but
15 is waiting for psychiatric approval before embarking,
16 I think he is very foolish. He might as well wait
17 forever.

18 This raises the question of
19 medical supervision for LSD sessions. I'll say this.
20 I can barely think of a setting less conducive to
21 a positive loving LSD experience, than taking it in a
22 cold clinical setting with a probing hard cold facts
23 doctor with no understanding of ecstatic states. I
24 would rather trip in a jail cell. I close this
25 section with a quote from Masters and Houston, from
26 their book, "Varieties of Psychedelic Experience."

27 "Totally committed as we are
28 to the position that sessions must be adequately
29 guided, we find it impossible to say on the basis of
30 many interviews and studies of the Drug Movement that

casualties have occurred among its members with a frequency as great as that among participants in many programmes directed by medical and other scientific personnel. What this means is only that in the case of the latter nonsupportive (including inquisitorial) experimenter attitudes wedded to a psychotomimetic expectancy have proved to be even more damaging than the most haphazard drug use occurring in a basically friendly and supportive session.'

As Timothy Leary said, to quote him, "Take LSD in an out house and you are going to have an out house **trip**." If you take LSD with a person whose terms of reference includes all of these psychological disturbances, you are likely to go through some psychological disturbances, take LSD to the doctor, likely to go through some episodes of disease symptoms, cancer and "Oh, my heart is stopping", and so on.

I will now talk about my own LSD experience, with philosophical elaboration. I have taken LSD 100-120 times. I have lost count.

I approached LSD from a standpoint of intellectual curiosity, aware of the claims to spiritual revelation but unread in these areas. My first trip, on about 70 mg., a low dose, was a beautiful experience of sensory enhancement, and general good easy being. At one point, though, I went into a panic, feared I was losing my mind, and was comforted and soothed by those with me.

On subsequent trips, on

The more complex, specialized the culture, the more complex the mold, the more thorough is its grip on the person. In primitive cultures, the mold fits loosely enough that it still allows some degree of inner flow and spontaneity, within the terms set by the mold, of course. Complex technological culture, on the other hand, lays on us a very detailed and restrictive mold very demanding of our

1 attention and dedication. We are required to give up
2 much more of our spontaneity and intuitive feeling to
3 the demands of complex role-playing, prescribed in
4 such a way as to co-ordinate all the parts of the
5 social machine, in the interests of optimum productive
6 functioning.

7 This role-playing is propped
8 by fundamental tightly held conditioned ontological
9 beliefs, judicial religious beliefs, basic and conscious
10 principals, such as, "hard work is the most important
11 virtue. The body is naughty. The intellect is the
12 supreme good. Man is the supreme animal God, the
13 father, grades us by our works, passed, failed and
14 so on".

15 Alan Watts gives a much more
16 literate and full presentation of this theme in his
17 book called The Book. Watts, incidentally, is a
18 distinguished theological thinker and writer, who has
19 had a tremendous influence on some of the newer terms
20 of thought. He was, almost alone, writing about
21 ecology and the harmonious interdependence of all life
22 forms several years ago, long before the issue gained
23 public currency. He has taken, he told me, about 60
24 LSD trips and has written a masterful description of
25 one such trip, a book called The Joyous Cosmology.

26 To get back to the psychology
27 of conditioning, conditioning closes, narrows human
28 awareness, focuses on specifics, breaks up the formerly
29 unitive whole organic field awareness. Marshal
30 McLuhan talks about this. Conditioning is necessary to

1 relate to others, but it narrows our freedom and
2 robotizes, automatizes us, by giving us automatic roles
3 to play and even automatic thoughts to think. What is
4 free choice? The old free will and determination.
5 Well, there is an election and Catholics --- the Prime
6 Minister, Pierre Trudeau and Robert Stanfield. Pierre
7 Trudeau appeals to certain conditions and responses
8 and Robert Stanfield appeals to certain conditioned
9 beliefs, the son of an underwear manufacturer, and
10 generally reacting to this --- I am not saying we are
11 completely conditioning, but --- but we
12 are conditioned today and its restrictiveness is higher
13 probably than in any other human culture throughout
14 time.

15 Now LSD suspends conditioning.
16 LSD does not wipe out conditioning. With a powerful
17 LSD hit, you slip free of the narrowing straight jacket,
18 your awareness flooded by many other messages and
19 stimuli which had prior been closed off because they were
20 not directly functional. But all your conditioned skills,
21 your language, your factual knowledge, your awareness of
22 the social amenities, remain, so that in effect you can
23 have your cake and eat it. You have the functional,
24 social benefits of conditioning without being fooled
25 and trapped in it. Now I should qualify this by saying
26 that in initial LSD trips when one is inexperienced, he
27 is so overwhelmed and carried away that he might lose
28 during the course of this experience, he might lose
29 his conception of his social roles, and might look very
30 confused. If a policeman comes up to him, he might not

1 know what to say. But with more psychedelic experience
2 you learn, you realize that you are conditioning and
3 your knowledge of social ways is still there and you
4 can resort --- you can be a thousand light years away
5 and can resort to the proper way to talk to policemen
6 when somebody comes up to you and starts inquiring,
7 and you can convince the policeman you are perfectly
8 straight and respectable. I even wrote a letter to
9 Richard Nixon once when I was high on acid.

10 With LSD, you slip out of
11 your personality, your identity, your roles which you
12 mistook for the real you, if you can. Some find it
13 easier than others to float free, weightless, away from
14 the tags and labels, away from the you you'd always
15 known. This is transcending the ego. It is a very
16 subtle art. I think it is the subtlest and most
17 demanding of all human arts. It has to be approached
18 with dedication, intelligence, patience. The ability
19 to suffer through moments of fear and dark depression
20 where everything is coming apart.

21 Many people can't do it. They
22 feel they can't do it, so they can't do it. And if
23 they don't want to, maybe they don't have the motivation
24 to do it, they just prefer to live in a safe world.
25 This is fine. When faced with the prospect of losing
26 all, they retreat, run to hold on to something familiar,
27 take up some familiar habitual activity, or engage
28 others in interactions. In a few cases, their panic
29 may be such that, especially if they cannot trust their
30 co-trippers, they may run off to the hospital, off to

1 some doctor who will cure them, offer some secure
2 framwork that they can hold onto. Guide their way
3 back to reality. This is the LSD bad trip. Generally,
4 these panic cases are given calming tranquilizers like
5 librium and sent home. Occasionally, the person is
6 hospitalized. In a very few cases, the shock leaves
7 them unsettled, disoriented, for weeks or even months.
8 We all know about these cases. That is all we ever
9 hear about. They happen rarely enough but the same
10 cases are brought in over and over again by LSD
11 opponents. Everybody knows about the orange man.

12 There is a much more prevalent
13 kind of LSD panic. This is the panic of those who have
14 never used the drug, in seeing all those young people
15 floating laughingly away from the matrix of their
16 societal values, saying incomprehensible things, engaging
17 in all that sex and nudity and orgiastic music, neglecting
18 the values of competition and success, becoming barbarians,
19 pagans. This is the panic that I and my LSD-using friends
20 are most concerned about, because it is the most wide-
21 spread and the most dangerous. It manifests in police
22 searches. I myself have been searched thoroughly head
23 to toe in the last three weeks. It continually threatens
24 us with imprisonment for pursuing our spiritual way.
25 Timothy Leary is presently serving time in jail.

26 I will mention two notable
27 cases of LSD panic. Subject No. 1. His name is Art
28 Linkletter. His daughter took her own life a while
29 back. Art Linkletter immediately attributed the suicide
30 to LSD. "LSD killed my daughter" the headlines screamed.

1 The facts of the matter, as mentioned casually in the
2 L.A. Times, are that according to friends, Diane
3 Linkletter had not taken LSD for six months previous,
4 had not taken it on the eve of her suicide. She had
5 been depressed, friends say, over career and other
6 personal problems. Said Art Linkletter, "She must have
7 had an LSD recurrence. She just wouldn't do things
8 like that." He said a few days later, "If Diane's
9 death gives me added ammunition in my fight against
10 these poisons, then it will have been worth it." To
11 this day Art Linkletter goes around accusing Timothy
12 Leary of murdering his daughter, and has been welcomed
13 in this capacity by President Nixon and by Senate and
14 House Committees.

15 Case No. 2 is Maimon Cohen.
16 He is a medical researcher at N. Y. University at
17 Buffalo. He set out to study LSD and chromosomal damage.
18 As a matter of procedure, his experiment starts along
19 the lines, to determine the effects of X and Y on Z.
20 Maimon Cohen's research read, "To show that LSD is
21 more harmful than some people think." His experiment,
22 which consisted of pouring mammoth swamping quantities
23 of LSD on test-tube cultures, was a resounding success.
24 LSD damages chromosomes. No legitimate researchers
25 accept his findings today, although the mass media do.
26 A recent issue of Science magazine, and I apologize
27 again, for lack of time, I cannot produce the issue
28 number, contains a strong critique of his work. Many
29 geneticists with no commitment to psychedelic drugs
30 feel that his research was not only clumsy, but

1 deliberately dishonestly contrived.

2 The present score board in
3 chromosome damage, according to Dr. Eugene Schoenfield,
4 reads 5 studies indicating no damage, and 4 studies
5 indicating the possibility of damage.

6 This will be difficult to
7 explain, this perhaps will be the most far out thing
8 I have to say, and you might just shake your heads in
9 complete dismay at this. But I, for one, feel that
10 LSD works only to the good of the body in all ways.
11 It is an experience of such radiant organic wholesome-
12 ness and good feeling. It is a holy meeting with God
13 so healthy in basic body sense. I feel that only good,
14 physical and spiritual can come from it. This is a
15 matter of religious faith. My existential choice to
16 either trust my own body intuition and sensation, or
17 rely on the confused, often distorted wranglings of
18 the medical profession. I have chosen the former
19 course. Many others have too. Time will prove us
20 right or wrong.

21 I have mentioned LSD panic.
22 For those who take high doses of LSD in a serious,
23 disciplined fashion, not stepping off out of fear or to
24 grab on to fascinating sensory side-stops along the way,
25 which are great fun, which occupy you and prevent you
26 from going further anywhere, for those who have learned
27 to go all the way with LSD, the rewards are awesome.

28 After about 20 to 25 trips of
29 exploration and learning to let go, I had my first full
30 mystical revelations, overwhelming total immersion in

1 the infinite love energy beyond desire, beyond fear,
2 beyond space and time. For some people this happens
3 on the first trip, for some people this never happens.
4 The whole parade of human endeavour, the whole history
5 of man's tortured strivings, always looking outward
6 for rectification, getting more and more wound up in
7 external symbols, divorced from his inner strength,
8 stands revealed. This is not God appearing in some
9 hazy cloud. It is direct real revelation, a certainty
10 and existential awareness far surpassing normal
11 certainty. And you can find better and more detailed
12 descriptions of this all over.

13 In 80 or 90 subsequent trips,
14 I have managed to attain this state, or variations
15 thereof, every time, and now it happens quickly,
16 smoothly and spontaneously upon ingestion of the pill,
17 doses varying from 200 to 400 mgs., with little of the
18 soul struggle and growing that accompanied early
19 attempts. I am now using LSD to attain spiritual
20 transcendence once a week. I am never bored on these
21 trips. Always new variations, always opening out more
22 to further explorations. After 120 trips, I have only
23 begun to tap the vast reservoir of life secrets we have
24 buried inside. Every trip is just so new, so astounding,
25 it is always the same state but it is never the same.
26 It is just a shattering, incredible experience.

27 The scientific explanation that
28 I accept as most plausible is that the DNA of each cell
29 of the body, which has been passed on from the DNA
30 of our forefathers, contains memories of past lives it

1 has inhabited. The DNA we have is essentially the same
2 that has been around since the beginning of life. On
3 LSD, you can trace this DNA chain through your forebears
4 right back along the evolutionary line, complete with
5 recollections of past species now extinct, right back
6 along the line of life, back into the womb, back to
7 the caves, back to the tropical forests, the swamps,
8 the antediluvian mud, the ocean, back to the first
9 spark of life. LSD trips commonly contain images of
10 ancient reptilian creatures, strange flailing life
11 forms. Mystical art, Hindu art, psychedelic art is
12 full of strange animals. I just picked up a book of
13 Hindu art the other day, and there they were. I
14 recognized them. And on very powerful trips, you
15 go back even further, beyond life itself, to pure
16 energy being, the brilliant flash of solar illumination,
17 the peak experience, nirvana.

18 I will now touch on a few
19 related theological issues.

20 Chemical transcendence vs.
21 natural transcendence; you have to appreciate that all
22 consciousness is rooted in biochemical processes.
23 The natural processes like fasting, meditation, so
24 called natural processes, all work by inducing changes
25 in the brain's chemistry, changes similar to those
26 induced by drugs.

27 Drugs have a long history of use
28 to produce ecstatic states. The Aztecs centered their
29 religion around peyote experiences. The magic mushrooms
30 are used by Indians today throughout southwest U.S. and

1 down through Mexico and Latin America, as part of
2 ritualized religious experience, the legitimacy of
3 which has been recognized in the U.S. by court decisions.
4 In Mexico they call the mushrooms God's flesh. Gordon
5 Wasson has found evidence of mushroom religion in,
6 among other places, New Guinea, Borneo, Siberia. There
7 is a suggestion that psychedelic plants were used to pro-
8 duce trance states at the oracle of Delphi.

9 These chemicals, and all
10 transcendental methods, act to counter conditioning.
11 The heavier and more dominant the conditioning, the more
12 powerful and shocking the method that must be used. In
13 ancient eastern cultures which practiced meditation,
14 conditioning was much lighter. It was easier to
15 transcent it. Today, in highly conditioned western
16 societies, very heavy personalities, only a powerful
17 method can enable one to get beyond his ego. This is
18 my opinion. I believe that powerful chemicals are the
19 natural method for people of modern and advanced
20 societies. Simple meditation can work with only a very
21 few people, and I have met one person who attained a
22 high mystical state on hashish. That is also very,
23 very rare. I can see this from observing the progress
24 of drug using and drug abstaining friends. I believe
25 that, for most people, LSD and similar substances, like
26 mescaline, are the only way to attain high transcendental
27 states.

28 I'll say this, there is no safe
29 way to transcend the ego. To get beyond the ego, you
30 have to make a long and perilous voyage, with all its

1 accompanying fears, whether you do it with drugs or
2 any other way. Zen Buddhism has its share of bad trips,
3 people who can't handle the changes. Any effective
4 spiritual way will.

5 Second issue, high all the
6 time vs. transient mystical states. Many people
7 criticize the LSD induced mystical states on the grounds
8 that they are transient. People want to stay high all
9 the time and they say that they can do it. Aside from
10 the question of the efficacy of meditation for modern
11 man, I believe that these criticisms show a misunderstand-
12 ing of cosmic consciousness. In the the ultimate
13 experience of satori, the white light of illumination,
14 one has effectively died. He is right beyond all life.
15 It is timeless, and quite irrelevant whether it lasts
16 5 seconds or 5 hours or 5 years. If one were to stay
17 there, he is effectively removed from all daily
18 functioning as a human being. I do not believe that one
19 should retire totally from life. As the mystical
20 experience ends, one is propelled back back into the
21 world to perfect his life, to live it in more holy,
22 loving, harmonious fashion. I believe that the goal
23 of these experiences should be to enrich one's
24 daily life.

25 The beauty of LSD is that it's
26 a quick up and quick down, and I think there is a very
27 important difference between people who follow drugs,
28 non-drug methods and people who follow chemical methods.
29 People who attain these states of LSD are always oriented
30 to this world, always very much concerned with what is

1 happening in this world, read the newspapers, active
2 participants in the world, whereas people who have tried
3 it often, tend to withdraw. And I deal with this in
4 the next issue.

5 Number 3, the charge that
6 LSD promotes withdrawl from society. In non-drug
7 spiritual methods individuals must detach and withdraw
8 from life in many ways, sometimes totally, sometimes
9 retiring to retreats for the rest of their lives.

10 Every genuine LSD mystic that
11 I have met is an active and productive person in
12 his daily life. LSD requires only a day away here and
13 there. Inherent in the psychedelic experience itself
14 are strong pressures to do, to create, to express
15 insights and your spiritual harmony in your daily
16 actions.

17 Often a transcendental experience
18 will prompt someone to drop out of some established
19 pattern of life he has been involved in, in one of
20 these painful-joyful revelations, he may see the self-
21 deception, the habitual automatic lifeless nature of
22 some things he may be involved in, and seek to remove
23 himself from these patterns, and find more meaningful
24 ways. People may drop out from one set of activities,
25 but they will feel strongly impelled to drop back into
26 a more harmonious, real, honest set. In my own case,
27 I was headed for a career as a sociologist when I started
28 taking LSD. Now I am headed for a career as a musician.

29 I would like to conclude with
30 the clear, simple statement that any law forbidding the

1 use or the trafficking of LSD, is a violation of my
2 religious freedom. While I don't believe this has any
3 constitutional or legal implication in Canada, I leave
4 the moral implications with you. I do not expect
5 anything less than public outrage when I propose the
6 legalization of LSD. But I urge you to encourage
7 extensive research, whereby a group of spiritually
8 oriented, responsible, educated people, can explore their
9 inner consciousness with all attention paid to good and
10 sensible scientific procedure. If the U.S. Government
11 can spend millions to send some men on dangerous
12 missions into outer space, then I think that the
13 Canadian Government can spend a few thousand dollars
14 to send some adventuresome people exploring inner
15 space, a project which I regard as infinitely more
16 important and significant.

17 One way or the other, the
18 younger generation has LSD, and is putting it to
19 righteous use. If the Government wishes to imprison
20 us, that danger will not deter us. The death penalty
21 could not deter me from keeping my contact with God,
22 and if I must at some time go to jail, I will go with
23 the proud awareness that I am part of a holy historical
24 brotherhood who have faced prison for their righteous,
25 gentle, loving spiritual practices.

26 DR. LEHMANN: Just tell me,
27 why did you have to bring DNA into that?

28 I understand and appreciate your personal testi-
29 mony of something that you are very expert on, a mystic
30 experience, but why on earth do you have to bring in

1 some theory which by no means is proven and is very
2 imperfect on memory, and bring in this solid biology?
3 What made you do this?

4 MR. GOLDEN: There are many
5 people who report the same visions as I experienced,
6 many published reports of all these creatures who seem
7 to be going back and going into more primitive life
8 situations, going back to your ancestors ---

9 DR. LEHMANN: And you had to
10 find a scientific explanation for it?

11 MR. GOLDEN: Masters and
12 Houston prefer another explanation, which is, everybody
13 must have picked up at some time or another, some
14 kind of information about evolution and then on LSD.

15 DR. LEHMANN: Why do you
16 have to explain anything?

17 MR. GOLDEN: Well, there is
18 no ---

19 DR. LEHMANN: You are a
20 scientist at heart?

21 MR. GOLDEN: There is no real
22 necessity. It sounds like a plausible theory to me.
23 As far as I am concerned, I am pretty well convinced
24 that I am undergoing a legitimate experience of prior
25 life and if the question is, how did I get back there,
26 the reasons for my being there,
27 the theory of DNA progression is that you can trace it
28 back along the DNA line.

29 DR. LEHMANN: Awfully
30 (pedestrian) and terribly compulsive and just doesn't

1 fit into your ---

2 MR. CAMPBELL: What about a
3 more union approach?

4 MR. GOLDEN: I'll explain
5 further. I was concerned with art type of themes,
6 right? The young never would have concerned themselves
7 or never really understood from where these art type
8 themes were derived. Hindu art is concerned with art
9 type of themes too. I think these art type of themes
10 have direct evolutionary routes and that they are
11 evolutionary like art types, and (Ewen) talks about the
12 collective consciousness that transcends the human
13 consciousness, a consciousness which is aware of past
14 life. This seems to fit into the DNA framework, but
15 if someone can come up with a better explanation, I am
16 not committed to this.

17 DR. LEHMANN: But why don't
18 you accept what is happening?

19 MR. GOLDEN: I do; I do. It
20 is always fun to try and understand it. And actually
21 it is not necessary.

22 THE CHAIRMAN: Well, you
23 have cast a spell over the assembly.

24 I guess we should leave it
25 there.

26 Thank you.

27 Thank you, very much.

28 So I will declare the hearing
29 here in Windsor terminated, and I thank all of you for
30 the reception of us here, and for your assistance, help

1 and patience. And I bid you good-night.

2 --- Upon adjourning at 7:05 P.M.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30



